CONVENTION NUMBER

the

Journal

of the association for physical and mental rehabilitation

CORRECTIVE THERAPY

MAY-JUNE 1954 Vol. 8, No. 3

Greetings From Cleveland

CONVENTION HEADQUARTERS

8th Annual Convention

Association for Physical and Mental Rehabilitation

Hotel Hollenden **June 28 through July 2, 1954**

WELCOME: To the Best Convention Location in the Nation

Cleveland, convention city of the nation, extends to you, your family and your friends a most cordial welcome. Every effort will be expended to make the Eighth Annual Conference fit your every wish.

The modern graciousness of Hotel Hollenden, located just six blocks east of the Square on Superior Avenue, assures all members and friends a hearty welcome. Their nationally famous "Vogue Room" promises the best in entertainment in an atmosphere of friendly companionship.

Cleveland, centrally located, is easily accessible by any and all means of transportation. If you are driving, Routes 20, 6 and 2 from the east and west and Routes 42, 21 and 8 from the south, lead directly to the heart of Cleveland. Major plane and rail lines provide excellent service into the city.

Catering to the most cosmopolitan tastes are restaurants, cafeterias, cocktail lounges and dine and dance spots available for your eating and dancing pleasure.

The Clinical Conference has been planned to provide an interesting and instructive program for the **whole rehabilitation team.** We have attempted to draw medical leaders from university medical schools, private practice and community facilities as well as the Veterans Administration. The panel type discussion presentation will be used with emphasis on practicality and instruction.

Based on the belief that valuable information is lost if the conference is projected over too long a period, we have planned the administrative meetings to be held Monday and Monday evening with the clinical sessions from Tuesday through Friday noon.

The most prominent manufacturers and distributors of physical medicine rehabilitation equipment will explain the helpfulness of the most modern equipment and devices. We have planned hours of conference to allow you ample time to visit each of these exhibits and to become acquainted with them.

Under the chairmanship of Mrs. Ruth Kirkwood, special efforts have been directed toward arranging a stimulating program for the wives.

Daily demonstrations of pertinent Corrective Therapy procedures will be conducted following the noon hour. Other special events are being planned both in the scientific and entertainment vein. Tuesday evening the Crile V. A. Hospital's Annual Rehabilitation Exercises, with a prominent speaker and demonstration of P.M.R. procedures, will be held in the grand ballroom of the hotel. A reception will follow the program by courtesy of the Veterans of Foreign Wars Auxillary.

Our annual banquet is scheduled for Thursday evening.

A glance at the baseball scheduled will show you that the New York Yankees play the last of a three game series Sunday afternoon, June 27th, and the Chicago White Sox invade the Indian teepee Friday evening, July 2nd.

Your officers and conference committees have made the above arrangements with you in mind. The success of the conference rests upon your attendance and participation. Make your plans now to join us in Cleveland, June 28th through July 2nd, 1954.

EARL B. RAYMER
Conference Chairman.

COMMERCIAL EXHIBITORS

Porto-Lift Manufacturing Co.
1412 N. Larch, P. O. Box 103
Lansing 5, Michigan

Massachusets Indemnity Insurance Co.
654 Beacon St.
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MAY-JUNE 1954

Volume 8 Number 3

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in this issue

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ARTICLES

DEPARTMENTS

THE JOURNAL OF THE ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION

Information For Contributors

MANUSCRIPT: Manuscripts should not exceed ten 10) typewritten pages; approximately 5,000 words. Manuscripts must be the original copy, not a carbon, typed double-spaced with margins of one (1) inch for large type and one and a half (1½) inches for the small.

STYLE: Prepare manuscripts in conformity with the general style of the Journal. Retain a copy of the manuscript and duplicates of all tables, figures, charts for future use should originals be lost in the mails.

ILLUSTRATIONS: Drawings and charts should be made with India ink for photographic reproduction as zinc etchings. Photographs must be 8 x 10 inches, high contrast, black and white, glossy prints. Printed captions and related information referring to photographs, must be typed and attached to the bottom of the photograph. All illustrations should not exceed 8 x 10 inches and are more acceptable when a smaller size does not sacrifice important detail. Redrawing and preparing illustrations, to make them suitable for photographic reproduction, will be charged to the contributor.

REFERENCES: References in the text, should be in the form of footnotes, numbered consecutively throughout the manuscript. Additional references for collateral reading should be assembled alphabetically by author at the end of the article. References should conform to the style of the Quarterly Cumulative Index Medicus. This requires in order; name of author, title of article, name of periodical or book, volume, page, month and year. For example: MORTON, DUDLEY J., *The Human Foot*, Columbia University Press, 1953. KRAUS, HANS, M.D., *Therapeutic Exercises in Rehabilitation*, Journal of Physical and Mental Rehabilitaton, Vol. 3, pp 7-10, June, 1949.

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SUBSCRIPTION RATES: Annual subscrption rate is $5.00, payable in advance. Association membership rates are: Active, $10.00; Professional, $5.00, and Associate, $4.00. SINGLE COPIES: Single copy price is $1.00.

REMITTANCES: All remittances should be made by check, money order, or draft. Never send cash except by registered letter. Make checks, money orders or drafts payable to the "Association for Physical and Mental Rehabilitation."

Inquiries and applications for subscriptions and all requests for change of address or membership should be addressed to—STANLEY H. WERTZ, SECRETARY, 1433 RAILTON ROAD, MEMPHIS, TENNESSEE.

Advertisers

ADVERTISING RATES: Full page $65.00—½ page $35.00—¼ page $20.00—⅛ page $14.00.
Classified Directory listing for one year, (6 issues)—$10.00.

ADVERTISING MANAGER: Dominic Cuda, 9251 W. Swann Circle, Milwaukee 16, Wisc.

GENERAL INFORMATION

REGISTRATION: Registration will begin at 8:30 A.M. Monday, June 28, 1954. The registration desk will be located in the Mezzanine of the Hollenden Hotel. The convention registration fee will be $10 which will include the cost of the banquet. Registration fee for single days will be $1 and will include morning and afternoon sessions.

BADGES: All members, guests, and visitors will be required to wear the appropriate official convention badge for admission to the convention assembly room. Those attending single sessions will present an admission ticket for admission which will be supplied at the time of registration. All speakers on the program are requested to register at which time an appropriate official badge will be issued which will admit speakers to all sessions.

HOTEL RESERVATIONS: Ample hotel accommodations should be available at the headquarters hotel. Those attending the convention will find that the Hollenden Hotel will offer the best in accommodations and special convention rates are reasonable. Anyone without hotel accommodations may inquire at the registration desk.

ENTERTAINMENT: Cleveland offers much in the way of entertainment and interest for those attending the convention. The social committee will have information for members, guests, and their families that will assist in selecting activities and sightseeing.

BANQUET: All members and guests attending the convention are invited to attend the banquet on Thursday night, July 1, 1954 at 7:00 P.M. Members will obtain tickets at the time of registration as the cost of the banquet is included in the registration fee of $10. Visitors may obtain tickets at the registration desk. Names of the principal speaker will be announced later.

COMMERCIAL EXHIBITS: Commercial exhibits will be located in the Ohio room, immediately adjacent to the assembly room where the sessions will be held. All those attending the meeting are urged to visit the commercial exhibits. A wide variety of rehabilitation equipment will be displayed and should be of considerable interest to those attending.

SCIENTIFIC EXHIBITS: The scientific exhibits will be located in the Ohio Room, Demonstration of Corrective Therapy techniques will be held daily in the Cypress room which is immediately adjacent. Additional information concerning these demonstrations will be found in the official program.

CONFERENCE COMMITTEES

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TENTATIVE PROGRAM

THE EIGHTH ANNUAL SCIENTIFIC AND CLINICAL CONFERENCE

Association For Physical and Mental Rehabilitation

Hollenden Hotel, Cleveland, Ohio

June 28 Through July 2, 1954

CONFERENCE THEME

Rehabilitation Today: A Dynamic Process with Many Facets and Participants

SUNDAY, June 27, 1954

9:00 A.M.-12:00 Noon—Meeting, Executive Board, Assembly Room

2:00 P.M.—Ball game: New York Yankees vs Cleveland Indians

MONDAY, June 28, 1954

8:30 A.M.- 5:00 P.M.—Registration

Morning Session

9:00 A.M.-11:00 A.M.—Meeting, Executive Board, Representative Assembly, Assembly Room.

11:00 A.M.-12:00 Noon—Exhibits, Ohio Room

12:00 Noon-1:00 P.M.—Luncheon

Afternoon Session

1:00 P.M.—Meeting, Executive Board and Representative Assembly

Tuesday, June 29, 1954

8:30 A.M.- 5:00 P.M.—Registration

Morning Session

8:30 A.M.- 9:30 A.M.—Exhibits—Ohio Room

9:30 A.M.-11:30 A.M.—Opening of Convention—Assembly Room

General Chairman: John Eisele Davis, Sc. D., Chief, Corrective Therapy, Veterans Administration, Washington, D. C.

9:30 A.M.- 9:45 A.M.—INVOCATION
The Very Reverend Percy Rex, Dean, Trinity Cathedral, Cleveland, Ohio

9:45 A.M.-10:15 A.M.—WELCOME — Speaker to be announced
WELCOMING COMMITTEE—Mr. John C. Phillips, Manager, Veterans Administration Hospital, Cleveland, Ohio
Harry T. Zankel, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Cleveland, Ohio
Leo Rosenberg, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Dayton, Ohio

10:15 A.M.-10:30 A.M.—RESPONSE
Harold M. Robinson, Chief, Corrective Therapy, Veterans Administration Hospital, Downey, Illinois

10:30 A.M.-11:15 A.M.—THEME ADDRESS
Speaker to be announced

11:15 A.M.-12:00 Noon—Exhibits

12:00 Noon- 1:00 P.M.—Luncheon

Afternoon Session

1:00 P.M.- 1:30 P.M.—Exhibits

1:30 P.M.- 3:00 P.M.

PANEL DISCUSSION:

REHABILITATION FOLLOWING REPAIR OF SHOULDER DISLOCATION.
Chairman Robert W. Newman, M.D., Professor of Orthopedic Surgery, University of Iowa.

"KINESIOLOGICAL DATA PERTINENT TO SHOULDER REPAIR"—C. A. Maxwell, M.D., Associate Medical Director, Kessler Institute, Surgeon-in-charge, Phillyesburg, Warren Hospital, Consultant, Orthopedic Surgery, Veterans Administration Hospital, Lyons, N. J.

"COMMON DISLOCATIONS AND OPERATIONS" — Henry H. Kessler, M.D., Medical Director, Kessler Institute for Rehabilitation, West Orange, N. J., Chief, Medical Staff, Hospital for Crippled Children, Newark, N. J., Consultant, Orthopedic Surgery, Beth Israel Hospital, Newark, N. J., Clinical Professor of Rehabilitation, N. Y. Med. College.

"PHYSICAL REHABILITATION FOLLOWING SURGICAL REPAIR"—J. L. Rudd,M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Brockton, Mass., Chairman, Massachusetts Rehabilitation Commission,—President, New England Society of Physical Medicine.

3:00 P.M.- 3:30 P.M.—Intermission—Exhibits

3:30 P.M.- 5:00 P.M.

PANEL DISCUSSION:

HIP JOINT ARTHROPLASTIES AND HIP JOINT REPLACEMENTS.
Chairman Robert W. Newman, M.D., Professor of Orthopedic Surgery, University of Iowa.

"RATIONALE OF ARTICULAR REPLACEMENT OPERATIONS"—W. H. McGaw, M.D., Chief Consultant, Orthopedic Surgery, Veterans Administration Hospital, Cleveland, Ohio

"RATIONALE FOR CUP ARTHROPLASTY"—Charles H. Herndon, M.D., Associate Professor, Orthopedic Surgery, Western Reserve University, Cleveland, Ohio, Chief, of Department of Orthopedic Surgery, University Hospital, Cleveland, Ohio.

"TECHNIQUES USED IN POST-OPERATIVE TREATMENT OF CUP ARTHROPLASTY"—George Heos, Corrective Therapist., Veterans Administration Hospital, Bedford, Massachusetts.

5:00 P.M.- 5:30 P.M.—Exhibits

WEDNESDAY, June 30, 1954

8:30 A.M.- 5:00 P.M.—Registration

Morning Session

8:30 A.M.- 9:00 A.M.—Exhibits—Ohio Room

9:00 A.M.-10:15 P.M.

PANEL DISCUSSION:

POLIOMYELITIS—A PERIPHERAL MOTOR NEURON LESION.

Chairman W. S. McEllroy, M.D., Dean, School of Medicine, University of Pittsburgh, Pennsylvania.

"CORRECTIVE THERAPY RETRAINING TECHNIQUES"—Hy Wettstein, Assistant Chief, Corrective Therapy, Veterans Administration Hospital, Bronx, New York.

"ORTHOPEDIC PROBLEMS IN TREATMENT OF POLIOMYELITIS"—Joseph Brown, M.D., Orthopedic Surgeon, Cleveland, Ohio.

"PHYSICAL MEDICINE REHABILITATION PROCEDURES IN TREATMENT OF THE CONVALESCENT 'POLIO' PATIENT"—Harry T. Zankel, M.D., Chief Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Cleveland, Ohio.

10:15 A.M.-10:30 A.M.—Intermission—exhibits

10:30 A.M.-12:15 P.M.

PANEL DISCUSSION:

REHABILITATION OF THE HEMIPLEGIC PATIENT.

Chairman—W. S. McEllroy, M.D., Dean, School of Medicine, University of Pittsburgh, Pennsylvania.

"PHYSICAL REHABILITATION OF THE HEMIPLEGIC PATIENT"—Florence I. Mahoney, M.D., Chief, Physical Medicine Rehabilitation Service, Veterans Administration Hospital, Memphis, Tenn.

"VOCATIONAL REHABILITATION OF THE HEMIPLEGIC PATIENT"—M. L. Royer, Vocational Director, Veterans Administration Regional Office, Cleveland, Ohio.

"DEMONSTRATION OF RE-TRAINING PROCEDURES IN CORRECTIVE THERAPY"—Harry B. Dando, Corrective Therapist, Veterans Administration Hospital, Minneapolis, Minn.

12:15- 1:30 P.M.—Luncheon—Exhibits

Afternoon Session

1:30 P.M.- 3:00 P.M.

PANEL DISCUSSION:

PATIENT EDUCATION — A SOCIO-MEDICAL ASPECT OF TREATMENT PRACTICE.

Chairman, George E. Beauchamp, Ph.D., Consultant, Patient Education, T. B. Service, Veterans Administration, Washington, D. C.

"PSYCHOLOGICAL METHODOLOGY ELICITING PATIENTS UNDERSTANDING AND CO-OPERATION"—Ralph Simon, Ph.D., Chief, Clinical Psychologist, Veterans Administration Hospital, Butler, Pennsylvania.

"UTILIZING NURSING RESOURCES IN PROMOTING PATIENTS RECOVERY" — Miss Dorothy Wheeler, Chief, Nursing Service, Veterans Administration, Washington, D. C.

"PERTINENT SOCIAL MEDIA AFFECTING PATIENTS RECOVERY"—Mrs. Margaret S. Bours, Chief, Social Service, Veterans Administration Hospital, Fort Thomas, Kentucky.

3:00 P.M.- 3:15 P.M.—Intermission—Exhibits

3:15 P.M.- 5:00 P.M.

PANEL DISCUSSION:

MODERN CONCEPTS IN TREATMENT OF THE GERIATRIC PATIENT.

Chairman—James F. Conner, M. D., Chief Professional Services, Veterans Administration Center, Kecoughtan, Virginia.

"THE ROLE OF THE INTERMEDIATE HOSPITAL IN THE CARE OF THE AGED" — Herman J. Switkes, M. D., Chief, Out-Patient Clinic, Veterans Administration Hospital, Kecoughtan, Virginia.

"REHABILITATION OF THE AGED"—Jack B. Porterfield, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Center, Kecoughtan, Virginia.

"PSYCHIATRIC PROBELMS IN CARE OF THE AGED"—Harold N. Kind, M.D., Chief, Neuro-psychiatric Service, Veterans Administration Center, Kecoughtan, Virginia.

4:30 P.M.- 5:00 P.M.—Reviewing by Chairman
Questions from the floor.

5:00 P.M.- 5:30 P.M.—Exhibits

THURSDAY, July 1, 1954

8:30 A.M.- 5:00 P.M.—Registration

Morning Session

8:30 A.M.- 9:00 A.M.—Exhibits—Ohio Room

9:00 A.M.-10:30 A.M.

PANEL DISCUSSION:

ADVANCES IN TREATMENT OF ARTHRITIS —

Chairman—Fritz Friedland, M. D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Boston, Massachusetts.

"CORRECTIVE THERAPY TECHNIQUES AND PROCEDURES"—Leo Berner, Chief, Corrective Therapy, Veterans Administration Hospital, Bronx, N. Y.

"RECENT ADVANCES IN THE MEDICAL TREATMENT OF THE ARTHRITIC PATIENT—Robert M. Stecker, M.D., Assistant Professor, Clinical Medicine, Western Reserve University, Cleveland, Ohio.

"PHYSICAL MEDICINE REHABILTATION CONTRIBUTION TO TREATMENT OF THE ARTHRITIC PATIENT"—Ferdinand F. Schwartz, M.D., Director, Birmingham Institute of Physical Medicine and Rehabilitation, Birmingham, Alabama.

10:30 A.M.-10:45 A.M.—Intermission—Exhibits.

10:45 A.M.-12:15 P.M.

PANEL DISCUSSION:

THE CARDIAC PATIENT AND HIS REHABILITATION.

Chairman—Harold Feil, M.D., Professor of Medicine, Western Reserve University Medical School, Cleveland, Ohio.

"THE COMMON PATHOLOGIES AND TREATMENTS OF CARDIAC DISEASE"—Bernard Broffman, M.D., Mount Sinai Hospital, Cleveland, Ohio.

"PHYSICAL MEDICINE REHABILITATION FOR THE CARDIAC PATIENT"—Herman K. Hellerstein, M.D., Director, Work Classification Clinic, University Hospital, Cleveland, Ohio.

"THE CARDIAC PATIENT'S PLACE IN INDUSTRY" —Don Kelly, M.D., Cleveland, Ohio.

12:15 P.M.- 1:30 P.M.—Luncheon

Afternoon Session

1:15 P.M.- 1:30 P.M.—Corrective Therapy Demonstrations in the Cypress Room

1:15 P.M.- 2:00 P.M.—Exhibits

2:00 P.M.- 2:30 P.M.
"THE MYTH OF CHRONICITY"—Harry T. Tomkins, M.D., Chief Neuro-Psychiatric Service, Veterans Administration, Washington, D. C.

2:30 P.M.- 3:00 P.M.—Exhibits—Ohio Room

3:00 P.M.- 5:00 P.M.

PANEL DISCUSSION:

DEVELOPMENT OF EVALUATION METHODS FOR ASSESSING EFFECTIVENESS OF CORRECTIVE THERAPY IN THE TREATMENT OF THE PSYCHIATRIC PATIENT

Chairman—A. B. C. Knudson, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration, Washington, D. C.

"EVALUATION IN RELATIONSHIP TO IMPROVED METHODOLOGY IN PHYSICAL MEDICINE AND REHABILITATION"—A. B. C. Knudson, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration, Washington, D. C.

"FROM THE STANDPOINT OF PSYCHIATRIC APPROACHES"—Speaker to be announced.

"THE PSYCHOLOGICAL APPROACH" — Ronald Wolfe, Ph.D., Chief of Psychology, Veterans Administration Hospital, Chillicothe, Ohio.

"SOCIAL CRITERIA FOR COMMUNITY ADJUSTMENT"—Emily Scanlon, Chief, Social Service, Veterans Administration Hospital, Lyons, New Jersey.

"UTILIZATION OF EMPIRICAL AND OTHER CRITERIA. A PRELIMINARY REPORT OF THE UTILIZATION BY CORRECTIVE THERAPISTS OF MULTIDIMENSIONAL SCALE FOR RATING PSYCHIATRIC PATIENTS"—John E. Davis, Sc. D., Chief, Corrective Therapy, Veterans Administration, Washington, D. C.

Evening Session

7:00 P.M.—Banquet—Main Ballroom
Master of Ceremonies—Ralph Stone, Deputy Administrator, Veterans Benefits, Veterans Administration, Washington, D. C.

Invocation—Rabbi Earl Stone, The Temple, Cleveland, Ohio

Principal Speaker—To be announced

Presentation of John E. Davis Award

Closing Prayer—Most Reverend Floyd Begin, S.T.D., Ph.D., J.C.D., Auxillary Bishop, The Catholic Diocese, Cleveland, Ohio.

Friday, June 2, 1954

8:30 A.M.- 9:30 A.M.—Exhibits—Ohio Room

9:30 A.M.-11:30 A.M.

PANEL DISCUSSION:

THE PLACE OF THE HANDICAPPED INDIVIDUAL IN OUR INDUSTRIAL SOCIETY

Chairman—Admiral Ross T. McIntire, Former Chairman, President's Committee on Employment of the Physically Handicapped.

"MEDICINE CHALLENGES INDUSTRY IN THE UTILIZATION OF THE AGED AND HANDICAPPED"—Thomas F. Barrett, M.D., Manager, Veterans Administration Research Hospital, Chicago, Illinois.

"INDUSTRIAL VIEWPOINT TOWARD EMPLOYMENT OF THE HANDICAPPED"—T. O. Kraebel, National Director, Rehabilitation Committee, American Legion.

"SELECTIVE VOCATIONAL PLACEMENT OF THE HANDICAPPED INDIVIDUAL"—H. Paul Messmer, Director, Selective Placement and Counseling, Ohio State Employment Bureau.

"PSYCHOLOGICAL ASPECTS INVOLVED IN EMPLOYMENT OF HANDICAPPED" — Harold Hildreth, Ph.D., Chief, Chief Clinical Psychology, Veterans Administration, Washington, D. C.

11:30 A.M.-12:00 Noon—Exhibits—Ohio Room

12:00 Noon-1:00 P.M.—Luncheon

PROGRAM FOR THE WIVES

CHAIRMAN, MRS. CHESTER KIRKWOOD

Two-room Suite reserved for wives at hotel

The New York Yankees play the Cleveland Indians Sunday, June 27 for those who come early.

Tuesday, June 29, 1954

2:00 P.M.—Get-together tea in suite
3:30 P.M.—OPTIONAL:Sight-seeing tour to Shaker Square

Wednesday, June 30, 1954

10:00 A.M.—Tour of Nela Park—Lunch
2:00 P.M.—Tour of Rose Foundation — Geriatric Hospital

Thursday, July 1, 1954

12:30 P.M.—Higbee tea-time style show
2:30 P.M.—Trip to Natural History Museum
OPTIONAL: Trip to Cleveland Art Museum

Friday, July 2, 1954

8:00 P.M.—Chicago White Sox vs. Cleveland Indians

Shopping and store guides will be furnished.

A U.S.A.F. PHYSICAL RECONDITIONING PROGRAM

LT. IVAN KUSINITZ

The U. S. A. F. Hospital at Sampson Air Force Base, New York is one of the newest and largest hospitals in the Air Force. It handles a large number of Neuropsychiatric and Orthopedic patients, with overall accommodations for approximately 1,300 patients. The patient load consists of overseas returnees, men in need of extensive treatment and base personnel who have been hospitalized. The load is distributed throughout ; a) Medical Service, b) Surgical Service, and c) Neuropsychiatric Service.

Since it is important that the fitness level of all patients be maintained or restored, Physical Reconditioning Section has been established.

DEFINITION: Physical Reconditioning Therapy is the process which aims to maintain or restore physical and psychological fitness through participation in progressively graded physical activities during the period of hospitalization.[1]

OBJECTIVES:

1. Allay and prevent deconditioning.
2. Accelerate physical recovery.
3. Restore a patient's physical condition to a level that will fit him for return to his assigned duties.
4. Contribute to psychological readjustment and resocialization by providing group activities in which patients can participate and in which they are afforded opportunities for self-expression and release from physical and emotional tension.[2]

SCOPE OF THE PROGRAM

Neuropsychiatric, medical and surgical patients participate in activities suited to their partcular needs. Since it is desirable that participation in physical reconditioning begin early during the period of hospitalization, ward activities are important.[3] When the patient becomes able to leave the ward, participation in graded gymnasium and outdoor activities is begun.

The program encompasses all patients in any of the following activities:

1. Activities on the ward.
2. Adapted sports and games.
3. Progressive weight training.
4. Remedial exercises.
5. Aquatic activities.

CLASSIFICATION

Due to the variety of disabilities, proper classification is of utmost importance for the provision of maximum and purposeful physical activities. Medical and surgical patients are classified according to the disability and degree of fitness (determined by the medical officer). As the patient's condition changes he is reclassified. The classification criteria for progressive weight training and adapted activities is as follows:

Progressive Weight Training

1. Group No. 1—Patients with normal use of skeletal and muscular systems.
2. Group No. 2—Patients with involvements of the trunk, viz., post-appendectomy, herniorraphy, spinal fusion, fractured vertebrae, etc.
3. Group No. 3—Patients with involvements of one upper extremity.
4. Group No. 4—Patients with lower extremity involvements. These must be ambulatory (wheelchair, crutches, cane, etc.)
5. Bed Patients—Orthopedic and surgical patients who are confined to bed.[4]

1. Group A—Patients in last stage of convalescence with no physical limitations.
2. Group B—Patients able to use their affected part to a limited extent.
3. Group C—Patients with post-operative weakness, back pain and weakness, and disabled upper extremity.
4. Group D—Patients suffering from extreme pain, ambulatory with use of wheelchair or crutches, or wearing a restricting body cast.

Careful and rapid progression to more strenous groups is accomplished as the physical condition of the patient improves. Neuropsychiatric patients are classified primarily according to special interests. Patients who are unable to socialize in team and group games, are handled individually. Gradual progression, here, is necessary for the purpose of resocialization.

ACTIVITIES

The activities are dependent upon the type of pa-

*Chief, Physical Reconditioning, Sampson Air Force Base, N. Y.

1. *Physical Reconditioning* A.F.M. 160-16, Wash.: p. 1, U. S. Government Printing Office 1952.
2. Ibid , p. 1.
3. Ibid., p. 2.
4. Kusinitz, I., and Andersen, H. R., *Weights in the U.S.A.F. Physical Reconditioning Program.*, Strength and Health, 24-25, January 1953.

(1) Participation in morning, "on the ward," calisthenics.

(2) Confined to bed, this patient exercises under careful supervision.

(3) Individual attention is important when administering remedial exercises.

(4) A class of orthopedic patients during a progressive weight training period. In the foreground group #3 patients (upper extremity disabilities) exercise alternately. The background depicts group #4 patients (lower extremity disabilities). Each class is composed of two groups.

(5) Patients enjoying a period of adapted activities.

(6) Recreation effective in resocialization.

(7) Free swim period prior to organized relay races and games.

(8) A swimming group participating in a shuttle relay.

(9) An orthopedic patient receiving instructions in basic archery skills.

(10) A run being scored in an important game of a patient softball tournament.

tients and the objectives of primary importance in their rehabilitation. Those with Neuropsychiatric disorders participate in a wide variety of activities. Because many of the patients are depressed and seemingly lethargic, it is important to expose all patients to the activity program. Usually after being an onlooker several times, the patient may show some interest. This is the crucial point at which, individual attention by the instructor can result in a new participant. Patients incapable of group participation are introduced to individual activities with gradual progression through games of low organization, to

(1) Participation in morning, "on the ward," calisthenics.

(2) Confined to bed, this patient exercises under careful supervision.

(3) Individual attention is important when administering remedial exercises.

(4) A class of orthopedic patients during a progressive weight training period. In the foreground group #3 patients (upper extremity disabilities) exercise alternately. The background depicts group #4 patients (lower extremity disabilities). Each class is composed of two groups.

(5) Patients enjoying a period of adapted activities.

(6) Recreation effective in resocialization.

(7) Free swim period prior to organized relay races and games.

(8) A swimming group participating in a shuttle relay.

(9) An orthopedic patient receiving instructions in basic archery skills.

(10) A run being scored in an important game of a patient softball tournament.

tients and the objectives of primary importance in their rehabilitation. Those with Neuropsychiatric disorders participate in a wide variety of activities. Because many of the patients are depressed and seemingly lethargic, it is important to expose all patients to the activity program. Usually after being an onlooker several times, the patient may show some interest. This is the crucial point at which, individual attention by the instructor can result in a new participant. Patients incapable of group participation are introduced to individual activities with gradual progression through games of low organization, to

mass games and then team activities. In all activities, methods which contribute to resocialization are emphasized. In calisthenics, patient leaders are utilized as are the techniques of mass commands, mass and cumulative cadence and competitive games. In other activities, frequent tournaments and league play are important in maintaining interest. The opportunity for self-expression and the sense of satisfaction through accomplishment contribute to the development of self-confidence and social competence. This supplements the total treatment which is designed to return the patient to full duty as rapidly as possible.

Orthopedic and other Surgical patients participate in an adapted activities program and a progressive weight training program. Archery, horseshoes, volleyball, goal-hi, shuffleboard and many other activities are modified to the disability. Weight training is an excellent activity to maintain and restore muscular strength.

In this activity the unaffected portions are exercised, thus maintaining general fitness.[5] Each patient has a personal exercise progress card. The fact that progress is easily noted in progressive weight training, adds greatly to its value as an activity for disabled patients. Weight training exercises are begun at bed side and are continued at the gym until recovery is completed. Principles of progressive resistance exercise are followed in administering specific remedial exercises.[6]

ADMISSION AND FOLLOW UP OF PATIENTS

When specific treatment is required, the physician completes a physical reconditioning prescription form, and forwards it to the Physical Reconditioning Office. The patient is placed in a group (depending on disability and Ward) and briefed as to his place as a participant. If progressive resistance exercise (progressive weight training) is prescribed, the patient is weighed and measured prior to commencing treatment, and every other week thereafter.[7] This, in addition to a carefully controlled exercise progress card presents a clear picture of the patient's physical progress as a participant in the program.

The patient's progress is reported to the physician at weekly Ward rounds and when otherwise necessary through personal communication between the physician and the physical reconditioning officer. After the patient's release from the hospital, his physical reconditioning record form is forwarded to the Registrar for inclusion in his permanent medical record.

5. Kusinitz and Andersen, *Op. Cit.*, p. 24.
6. DeLorme, T. L., and Watkins, A. L., *Progressive Resistance Exercise*, New York; Appleton-Century-Crofts, 1951.
7. Circumference of chest, upper arm, forearm, waist, thigh, etc., are recorded to indicate progress.

CONCLUSION

At present one officer and eight trained airmen make up the staff of an expanding physical reconditioning section. The fact that physical reconditioning at Sampson is increasing its effectiveness, is largely due to the encouragement of the medical officers. Most physicians are cognizant of the benefits of physical education and recreation for all types of patients. The orthopedic surgeon knows that exercise is important in the convalescence of his patients, while the psychiatrist seeks a program in sports and games for patients under his care. The fact that an average of approximately 250 patients participate daily is indicative of increased medical and patient interest in Physical Reconditioning.

THE SUNSHINE KITCHEN AND GARDEN IN THE REHABILITATION OF POST LOBOTOMY FEMALE PATIENTS

J. C. TATUM, M.D.*

This 1000-bed hospital (neuropsychiatric) has performed lobotomies or psychosurgery on 154 patients during the past five years. Of the total number, 38 were females. The hospital is predominately for male patients, having facilities for caring for only 85 female psychiatric patients.

The female service in a hospital of this type is a complete separate functional unit as they necessarily require a certain amount of specialized care and isolation from the male patients. They need separate dining room facilities, separate occupational therapy and hydrotherapy departments. Privileges are denied the greater portion of them due to their sex, and the rehabilitation program for the above reasons becomes more difficult. The varied activities as furnished by the Medical Rehabilitation Department and the Special Services programs are adequate in the care and treatment of the male patients, but in the female there is a factor missing, the close-to-home element and the home environmental-like factors. With the lobotomized female patients the need for some type of home re-training became not only markedly apparent but a necessity. The lack of a home retraining project was recognized by one of our volunteer advisory veterans service workers who came forth with the idea of establishing a kitchen and a garden to be called "The Sunshine Kitchen and Garden," to be supervised, furnished and operated by the ladies of the American Legion Auxiliary.

A corner space on the ground floor of the Acute Intensive Treatment building with a southeastern exposure was selected as an ideal room for the project as it was close to both the female and male wards that housed the patients in the lobotomy program. The room, approximately 20 ft. x 14 ft., was divided by partitions into a kitchen and dining alcove resembling a breakfast room, floored with asphalt tile, painted; adequate light fixtures and electrical outlets were installed by our Engineering Department. The room was elaborately decorated by objects made in the women's occupational therapy shops and adequately furnished with all the necessary items for a model kitchen and breakfast room. The furnishings include an electric stove, electric ice box, kitchen cabinets, cupboards, electric kitchen clock, toaster, a modern sink, a breakfast room table with chairs, table cloths and napkins, a complete set of dishes and silver, service for eight, a percolator, a mix-master, kitchen utensils and numerous other articles needed in a kitchen. The Sunshine Kitchen upon completion was elaborate as well as complete.

Due to the limited number of patients who could adequately use the kitchen, a team of five post-lobotomy females supervised by one therapist and a volunteer worker began the home re-training project three and one-half years ago. One patient out of the team of five was designated as the hostess for the day, one as the cook, one as the waitress or maid, one as the dishwasher and the remaining one as the guest. The hostess would issue invitations to five of the male lobotomy patients for the noon meal, and each patient on arrival of the guests would play her respective role. All female patients helped in cooking the meal under the direction of the appointed cook and the therapist. The hostess was instructed by the therapist to keep a critical eye on all of her helpers for the day and to call to their attention any violation of accepted social etiquette. The patient roles were alternated daily.

In this project they are taught the finer arts of cooking; a cook book is available and used extensively. They learn to set a table, wait on a table, and are taught manners that would be acceptable to either formal or informal company. All meals cooked and prepared are served to eligible hospital guests, and numerous families of patients returning home have complimented the program.

On Friday afternoons the lobotomy female patients give a tea for the twenty deep coma insulin cases (both men and women) at which time the team of five entertain this specialized treatment group in the Sunshine Kitchen with refreshments consisting of tea or coffee, cookies and sandwiches. This phase of the program has a therapeutic effect on the insulin patients as well as on the female hostesses.

In addition to the Sunshine Kitchen, a Sunshine Garden was established and many various vegetables have been raised by the female patients during the spring and summer months. The patients are proud of the vegetables raised in their garden, and they are products that are as good or better than can be bought in the local stores. These vegetables are planted, worked, gathered and cooked by these patients and are served to guests of the patients during the

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noon meal hour.

This short intensive therapy has been given to each female lobotomy patient during their six-weeks rehabilitation care prior to going home following the psychosurgery. The Sunshine Kitchen and the Sunshine Garden were established primarily for patients having had psychosurgery as a home re-training project, but when post-lobotomy patients were not available in sufficient numbers, marked success has been obtained with other female neuropsychiatric patients, in furthering their successful care and treatment. The female patients have been asking to be assigned to this project and it has attained a definite therapeutic value and consideration is being given to the idea of expanding this project whereby all female patients can receive this type of therapy.

The home re-training project has placed the patient in a home-like atmosphere several hours a day, five days a week. It is the closest factor that we have to home environment. Patients are given the opportunity to see what they can do under different situations and feel more secure while experiencing these situations while still under supervision of the hospital. It is a type of psychodrama that is useful in how to act after leaving the hospital. It restores confidence in the patient who is fully aware that an operation has been performed and possibly changed the brain structure. Instead of being dull and inadequate they find that even though something has happened it has not effected their power to think, to act, and they are able to resume their duties as housewives, or other normal occupational duties in the home. The project has filled a gap between the hospital and the home by injecting factors that can be helpful in a successful readjustment after leaving the hospital. Thirty-eight women patients have received the operation; all have received the benefit of the six weeks intensive rehabilitation program, of which the Sunshine Kitchen and Sunshine Garden are a part. Twenty have been discharged from the hospital, one is on trial visit and eight have returned here for further care, eight have remained hospitalized and one died of a heart condition. Four of the sixteen now in the hopsital are capable of community adjustment under supervision but home situations and lack of funds have prevented either a discharge, trial visit or foster home care.

SUMMARY: The Sunshine Kitchen and Sunshine Garden as part of our Medical Rehabilition Program:

Serves as a method of guiding the patients through an extremely important phase of their life as they are re-entering a world that appears as a reality or approaching reality, where in the past unreality has more or less predominated. This period may well be called the reclamation period during which time the proper behavior and work patterns are being re-established, thus preparing the patient for a re-entrance to her community, family and social life.

Motivates all patients, particularly the depressed and the lethargic, by making available a friendly home-like atmosphere similar to the one they were accustomed to prior to the onset of their mental illness.

Benefits the paranoid and hyperactive patients by closer supervision, by near contact and pleasant working relationship with both the personnel and her fellow ward patients, thus allaying fears and anxiety states.

Re-establishes confidence in the post-operative lobotomy patient by actual demonstration that they are still capable of a social as well as a useful life.

Is a means of allowing social contact between the women and men lobotomized patients during the noon meal, bringing the patients in contact with individuals of similar circumstances, similar in respect to their own mental conditions, and with similar operations. With a grouping of this nature the individual patient is able to visualize that many others have the same difficulty, and that they are not alone in the newly created situation. By visualization of others they can visualize themselves and by association with individuals with whom they have so much in common, the entire group is more able to re-establish themselves socially in a gradual manner.

APPRECIATION TO EDITORIAL BOARD AND STAFF

May I take an Editor's privilege and this opportunity to express sincere appreciation to the Editorial Staff and Board. Without their faithful help it would have been impossible to develop the Journal in its present form. The publication of the Journal of this Association is no longer a one-man job. It takes the coordinated and self sacrificing labors of many interested persons. It is hard to find words that accurately express my heartfelt gratitude toward all who in any way have helped bring the Journal to its present status.

In turning over the opportunity, privilege and responsibility to the editor-elect, may I urge the membership to recognize the responsibility that is theirs, in preparing copy in acceptable form and presenting it in time to meet "deadlines." These must be met if the Journal is to arrive in your mailbox regularly.

REMOVABLE ARM RESTS FOR WHEEL CHAIRS WITH DESK ARMS

RICHARD C. BARR* AND F. W. S. MODERN, M.D.**

In many types of disability it is to the patient's advantage to have a wheelchair with padded "desk arm rests." Such an arm rest permits him to sit close enough to a desk or table to feed himself, to exercise, to do occupational and diversional activity, resulting in more self care and independence.

In some instances ,these advantages are outweighed by disadvantages. The main disadvantage is that the desk arm rest does not provide support for the patient's forearms, wrists and hands. In order to support his arms, the patient must sit with his elbows fixed (45°) on the arm rests, the arms are rotated medially at the shoulders and the patient's hands rest in his lap. This makes for a poor sitting posture and may lead to difficulties if the patient is permitted to continue that way. On the other hand, if the forearms are extended on the arm rests the hands and wrists are without support, thus permitting wrist drop, which is also undesirable.

These and similar problems were exemplified by a post polio patient who had weakness of the upper extremities and trunk and who was sitting in a "cramped position" because of lack of support to his forearms. The patient needed the desk arm rests to permit him to get in close to a desk or table, which enabled him to feed himself, read and turn pages and do diversional and occupational work unaided. (It is suggested by the manufacturers that the arm rests can be turned around for tray use, etc.; this eliminates wrist drop but still does not give elbow support nor does it enable the patient to sit in the erect position.)

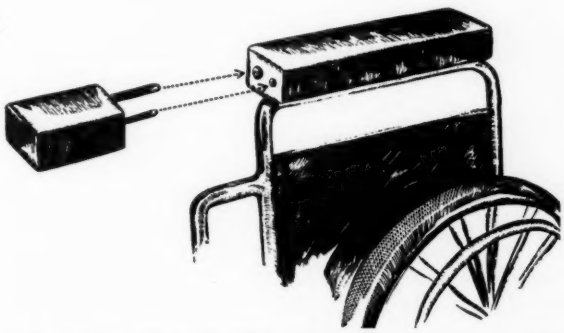
It was felt by the authors that the "return to normal" progress of the upper extremities was being hindered by restriction of movement due to the construction of the desk arms. The following modification was tried and proved effective.

The padded arm rests were drilled at the face paralleling the long axis with two separate holes 1 inch apart, so that one 1-3/4 inches deep and one 2-1/2 inches deep would take 1/4 inch and 5/16 inch metal dowelling respectively.

Two additional wooden arm rest pieces 1 inch thick, 6 inches long and 2 inches wide were constructed. These correspond to the full length of a standard arm rest when added to the permanent wheelchair desk arms. Two holes, 1-3/4 inches deep and 1 inch apart were drilled in the face of these pieces to receive two metal pieces of dowelling, one 1/4 inch in diameter and 3-1/2 inch in length and the other 5/16 inch in diameter and 4-1/4 inches in length.

with extension

without



The two metal dowels are glued firmly into the arm rest extension. It was then possible to attach the removable extension arm to the permanent arm by merely inserting the metal dowels into their respective holes. The two different sizes of metal dowelling prevent any possibility of getting the arm extensions reversed* and the difference in length makes it easier to insert them into the face of the permanent arm rest. With the longer dowel inserted first this makes a solid guide so that the other can be inserted with ease.

The arm rest extension was finished by padding it ontop with 1/2 inch sponge rubber and covering it with upholstering to match the original wheelchair desk arm.

Summary:

The authors have presented inherent problems in

(Continued on Page 86)

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*The dowels can be made uniform in circumference making the extensions interchangeable.

THE ARMY RECONDITIONING PROGRAM IN JAPAN

WILLIS P. DENNY, CAPT. M.S.C.*

The subject for this period is "The U. S. Army Reconditioning Program in Japan." Never before in the history of medicine has interest in and emphasis on the management of convalescence received such widespread attention as during and following World War II and Korea. The extensive programs in convalescent reconditioning developed by the armed services have been accorded universal recognition. I have just returned from the Far East where I served for approximately 28 months as Physical Reconditioning Officer in one of the Armys' outstanding General Hospitals located in Japan. This paper will cover (1) Our arrival in the Far East; (2) the facilities and equipment available; (3) the organization and development of the Physical Reconditioning program; (4) the adjustment of the program to meet the needs of the patients which we received, and (5) the personnel available, and the techniques and principles we employed to accomplish our ultimate objective, i.e.: to return the patient to duty in the best physical and mental condition within as short a time as possible. The attainment of this objective took on added significance in Japan since manpower was a vital factor in the accomplishment of the Armed Forces mission in Korea.

(1) *Arrival of the Unit in the Far East*:

The General Hospital was organized in late 1950 and departed for the Far East in early 1951, debarking there after approximately a two week voyage. I have mentioned this because I feel that it was a most important factor in the subsequent success of our Physical Reconditioning program. Prior to departure of the unit, a number of young Medical Officers, called for their first tour of duty with the Armed Forces joined the hospital. These officers had little or no concept of the purpose and objectives of a Physical Reconditioning program the organization of which was soon to become my responsibility. The close association with these doctors throughout the trip afforded an excellent opportunity to discuss with them the problems related to the operation of a successful Reconditioning program. These discussions established a strong liaison which was most helpful in later establishing the program. Arriving in the Far East, the unit was transported to the site selected for the new hospital. This site had previously served as a Japanese Naval School and more recently was occupied by a United States Infantry Regiment which had departed for Korea. Within a few days our equipment began to arrive and the hospital was directed to become operative within 72 hours. This required around the clock efforts by all personnel in order to meet this directive and at the appointed time the hospital received its first evacuees from Korea.

No doubt, most of you are familiar with the definition of Physical Reconditioning. It is the process thru which physical, social, and psychological fitness is maintained and/or restored thru participation of the patient in progressively graded physical activities during the period of hospitalization.

PURPOSE: The purpose for which the program is designed is (1) Prevent deconditioning and atrophy of the unaffected parts of the body brought on by prolonged bed rest: (2) Accelerate recovery of the patient and (3) Restore the patients' physical condition to a level that will enable him to return to his assigned duties in the Army by developing his strength, endurance and agility. The Physical Reconditioning officer and his staff are, and were at that time, responsible to the Chief, Physical Medicine Service for the successful accomplishment of the mission and objective of the program.

(2) *Facilities and Equipment Available*:

Our Physical Reconditioning staff was charged with the responsibility of developing the facilities and program consistent with the other sections and services of the hospital. Our time was limited but the facilities available proved ideal and the equipment was adequate. There was a completely equipped gymnasium, to be used for adapted Sports and Games such as: shuffleboard, table tennis, volleyball, badminton, basketball and many other suitable activities. Adjacent to this was a fine swimming pool which eased the problem of developing an Aquatic program involving activities of both a functional and diversional nature. The departed Regiment left an ample supply of Special Service equipment. This was used in developing a corrective and remedial therapy clinic. The Physical Reconditioning and Physical Therapy Clinics were located adjacent to one another. This resulted in very close coordination, thereby enabling us to obtain the maximum results in the care and treatment of all patients referred to our sections in the shortest possible time. What more could be asked for in the way of equipment, facilities, and cooperation?

(3) *Development of the Physical Reconditioning Program*:

Since this was a newly activated hospital starting from the ground up, it was necessary to devise a

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prescription form on which the Medical Officer could indicate the diagnosis, treatment desired and contra-indications, if any. Next, it was necessary to devise a treatment card or form on which could be recorded the treatments and progression of the patient. These forms were reproduced locally after receiving the approval of the Commanding Officer. At this time, the Chief, Orthopedic Section, was given the additional duty of Chief, Physical Medicine Service. Later, the Chief, Professional Services provided an opportunity for me to speak to the doctors of the hospital staff. During this orientation, the following items were discussed; the several phases of Physical Reconditioning and how each functioned, the referral of the patient to the Chief, Physical Medicine Service who, in turn, prescribed the treatment to be accomplished by the Physical Reconditioning section.

Therefore, through the cooperation and backing of the Commanding Officer, the Chief, Surgical Service and the Chief, Orthopedic Service, the establishment of the Physical Reconditioning program was given additional emphasis. These officers were thoroughly familiar with the results that might be obtained through a concerted Physical Reconditioning program. The Physical Reconditioning staff consisted of one Physical Reconditioning officer and three Non-Commissioned officers. All personnel had attended the Physical Reconditioning course established at the Medical Field Service School, Fort Sam Houston, Texas, and had gained considerable experience in Physical Reconditioning at other General Hospitals within the Continental United States.

The program was divided into 4 distinct phases: (1) the Bed program; (2) the Ambulatory program; (3) the Convalescent program, and (4) the Neuropsychiatric program. Each phase of the program was designed to meet the need of the patient.

The primary objective of our Bed Program was to prevent deconditioning and atrophy of the unaffected parts of the body brought on by prolonged bed rest and to maintain muscle tone of the body to the highest possible degree. This was accomplished by the use of resistive exercises, both manual and thru the use of graduated weights. The majority of the patients participating in this phase of the program were Orthopedic as many of those returned from Korea had suffered gunshot and shrapnel wounds resulting in fractures of both the upper and lower extremities.

Daily, resistive exercises to the unaffected parts of the body enabled the patient to increase circulation, maintain good muscle tone which, in turn, aided in accelerating the healing of his wounds. The remainder of this group of patients were those who had undergone surgery and, in general, the same type exercises were prescribed. Very few patients of the Medical Service were referred for treatment in this phase of our program as most of our medical cases hospitalized were those suffering with Hepatitis, Upper Respiratory Infections, etc., requiring complete bed rest in the early stages of medical treatment.

As the patient became ambulatory, he was referred to the Physical Reconditioning clinic for specific corrective or remedial exercises or for general conditioning exercises. Those referred for specific corrective exercises were treated by means of heavy resistive exercises, the use of graduated weights and other corrective apparatus such as: wall and chest pulleys, bicycles, rowing machines, etc. Efforts were made to restore strength and full Range of Motion to the lower extremities thru application of DeLormes' technique. Those referred for general conditioning were given specific periods of prescribed ambulatory exercises and were required to participate in a program of adapted sports and games. Those with extremely weakened muscles and loss of range of motion were treated in the therapeutic pool and were also required to participate in our program of adapted activities. These patients were permitted their choice of activities unless contra-indicated.

As they reached a point where daily definitive care was no longer necessary, they were transferred to the Convalescent Section of the hospital which was maintained in regular company type barracks. The Physical Reconditioning officer was responsible for the operation of this section which was comprised of approximately 150-200 patients. By removing the patient from the hospital atmosphere, it was possible to begin the restoration of the patients' self confidence and to restore his physical and mental condition to a level that would enable him to return to his assigned duties. When he was transferred to the Convalescent Section, his chart accompanied him and he was seen at least once each week by the medical officer assigned to the section. Progress notes were recorded on his chart and any contraindications noted if the patient was unable to participate in all phases of the program. At this time, all patients were classified into groups designated as 1, 2, 3 or 4.

Class 1 indicated that the patient was to take care of his housekeeping details and perform only light duties of a sedentary nature. Class 2 indicated the patient was not to engage in lifting or other activities requiring prolonged weight bearing. Class 3 indicated that the patient could participate fully in the daily program, with exceptions, as prescribed by the medical officer. Class 4 indicated that the patient was ready for full participation, with no exceptions, in a program of one to two weeks duration and upon completion of this period, he would be returned to duty.

Soldiers of Infantry and Engineering outfits whose units were engaged in combat usually required more conditioning activities than were provided by our hospital. These individuals were then transferred to one of the large Convalescent centers operated by the Army in Japan.

In the Convalescent section of our hospital the individual began the routine of a soldier again. He was responsible for all housekeeping details, police of the area, and meeting all formations. The men were formed into platoons and were required to participate in a daily program on a basis commensurate with their disabilities. The basic program consisted of progressively graded group exercises, sports and games and road marches. Upon reaching the desired physical and mental fitness, he was returned to duty via the Pipeline. When a patient reached the ambulatory or convalescent stage of treatment, we felt sure that he would return to duty. Consequently, the program was increased in intensity in order to restore him to the best possible physical and mental condition. Patients, arriving at the hospital who had suffered compound, comminuted fractures, loss of one or more of the extremities, serious abdominal or chest wounds were immediately evacuated to the ZI (continental U.S.) for further treatment.

(4) *The Psychiatric Program*:

In the Neuro-psychiatric program, efforts were made to assist in the resocialization of the patient thru planned participation in various activities such as volleyball, horseshoes, croquet, badminton, swimming, softball, bowling, etc. These activities, in addition to promoting their resocialization also served to improve and maintain their physical condition. The patients participating in this program were from the open wards and, usually, after several weeks of intensive therapy, many of them were transferred to other wards in the hospital, then to the Convalescent section, and eventually returned to full duty.

Through the cooperation of the medical officers of the hospital, the percentage of patients participating in the Physical Reconditioning program averaged approximately 38% and at times, as high as 55% of the patients within the hospital were participating in one phase or another of the Reconditioning program.

(5) *Personnel*

At the end of approximately 1 year, the personnel situation became acute as the enlistments of the P.R. technicians began to expire and they were all anxious to return home. Within a few months though, there were many well trained P.R. technicians arriving in the Far East. These replacement personnel proved to be well trained and possessed a great deal of practical experience gained in Army hospitals in the continental United States and therefore provided continuity in our program in the Far East. These instructors, after having been observed in their work by the medical officers and *they, the Medical Officers,* seeing the wonderful results being obtained, the technicians' thorough knowledge of Anatomy, Kinesiology and Muscle function, soon gained the complete confidence and respect of all the doctors.

Approximately 98% of the patients received in the hospital were admitted direct from Korea. Very few of these men were readmitted to the hospital once they were discharged which is a tribute to the effectiveness of the Physical Medicine Program. The remaining 2% of the patients were admitted from organizations in Japan. Although there was a shortage of Physical Reconditioning officers in Japan, I understand that P.R. officers were sent to the Far East as requested but many of these officers were diverted to other duties due to the necessity of the situation at that time. Consequently, several hospitals were hampered in their efforts to establish and operate a Physical reconditioning program. I was fortunate in having the opportunity to visit and observe the programs of other General Hospitals in Japan and those that were able to maintain and operate a Physical Reconditioning program did so in a very efficient manner and accomplished remarkable results.

In summarizing, I would like to say that my experience in the Far East has convinced me of the need of a dynamic Physical Reconditioning program in every General Hospital and especially, within those established in oversea areas. Also, that early and positive treatment, directed and prescribed by competent Medical personnel, will materially decrease the man days of hospitalization and consequently, decrease the drain upon manpower of the Armed Services of the United States; that a progressive well supervised Physical Reconditioning program will eliminate the need for the patient to return to the hospital for further treatment of his original cause of admission.

"From Other Journals"

J. N. NORRIS et al, "Coronary Heart-Disease and Physical Activity of Work," *The Lancet*, XXI:1053-1057, November 21, 1953.

Study of coronary heart-disease suggests that there has been a true increase of it. A study of about 31,000 men, aged 35-64, employed by the London Transport, showed it first presents itself clinically in one of three ways: as angina pectoris (about 1/5 of all cases), as coronary thrombosis which is not rapidly fatal (about one-half of the cases) and as coronary thrombosis fatal in the first three days (between a quarter and a third). Conductors were found to have less coronary heart-disease than drivers, but had much more angina pectoris. These differences may be due to constitutional factors, causing men to select different jobs, mental strains in the work, or the amount of physical activity involved. A study of Postal workers showed that the total incidence of coronary heart-disease is lower in postmen with a physically active job than in men in the sedentary positions, but the incidence of angina is higher. The findings of these two studies suggest that physical activity at work is important in relation to the coronary heart-disease of middle-aged men.

PJR

H. SILVERSTEIN, "Physical Medicine for the Aged and Chronically Ill," *The Canadian Medical Association Journal*, 70:31-34, January, 1954.

The aim of physical medicine in the management of the aged and chronically ill is to restore maximum degree of personal care and independence by physical therapeutic measures. Heat is the most effective and useful means of relieving pain, stiffness and muscle spasm. It also increases peripheral circulation. However, care must be taken with the aged suffering from diabetes, arteriosclerosis and other peripheral vascular disease. Massage relieves muscle spasm, increases local circulation and lessens swelling. Hydrotherapy relieves pain, stiffness, muscle spasm and increases the range of joint movement. Weakened muscle can be actively exercised in water with a minimal expenditure of energy. Remedial exercise should be encouraged. Stiff joints in the aged must be mobilized early to avoid permanent deformity and loss of motion. Careful guidance is necessary so as to avoid fatigue and increase in pain. Resistance exercises are instituted with improvement, so as to improve muscle tone and power.

PJR

J. N. NORRIS et al., "Coronary Heart-Disease and Physical Activity at Work," *The Lancet*, CCLXV:1111-1120, November 28, 1953.

An extended study of large numbers of transport and postal workers led to the hypothesis that coronary mortality is lower during middle age among heavy than among light workers. Heavy workers tend to have coronary heart disease in a more benign and chronic form than light workers, and to die more commonly than light workers in second or later episodes of the disease. An intimate functional association of the psychological with a general physical factor, such as activity seems unlikely. Nevertheless it is quite conceivable that at the biological level physical activity in work performs a stabilising function, such as channelling aggressive drives, which may be important in highly civilized societies and possibly revelant to conditions such as coronary heart disease. It is possible that greater physical activity benefits the coronary circulation, or lessor activity damages it, or both. Satisfactory evidence on the effects of sunlight, outdoor life, sedentary posture, sudden or violent physical effort, dietary habits, obesity, hypertension, occupational factors other than physical, responsibility, mental work and social factors are not available. It may be pointed out that there has been a real increase in coronary heart disease during a period in which heaviness and hours of work have declined. We need evidence as to whether physical activity *outside* of work, as in exercise and games, can compensate for lack of physical activity *in* work. If exercise is taken up late in a chairborne life it may conceivably even be harmful.

PJR

W. RITCHIE RUSSELL and M. FISCHER-WILLIAMS, "Recovery of Muscular Strength After Poliomyelitis," *The Lancet*, CCLXVI: 330-333, February 13, 1954.

The measurement of the maximum strength of a muscle group is at best a rough approximation. A simple spring is adequate for this type of measurement. Measurements in seventy paralytic cases indicate that improvement begins 3 or 4 weeks after the onset oof poliomyelitis and that there is a steady increase of strength for 30-40 weeks, by which time further recovery becomes very slow, and in some cases ceases. Experimental periods of lifting a weight or exercising against springs for a week had no very obvious effect on the curve of recovery so far as maximum strength is concerned. In some cases a quickening of the rate of improvement followed the exercise. It was often noticeable that the number of times the weight could be lifted increased considerably. The pattern of muscle recovery is difficult to explain. There is nothing which would suggest nerve regeneration. Recovery may depend firstly on hypertrophy of the surviving muscular or neuronal accounts, and secondly on a reorganization of the connections to the surviving motor cells. The latter may explain the surprising achievements of the patient really determined to stimulate his weak muscles.

PJR

SIDENY KATZ and JOHN H. DINGLE, "Antihistamines and the Common Cold," *The American Journal of Nursing*, 54:179-180, February, 1954.

In 1947 the first of a series of studies was reported which enthusiastically hailed the beneficial effects of anti-histaminic drugs in the treatment of the common cold. In evaluating these studies, they were found to be inadequate in relation to certain basic principles of disease investigation. It was not proved that the subjects were suffering from colds, adequate controls were not established and there was no factual basis to indicate antihistamines should have a beneficial effect on the common cold. Since then a number of properly controlled studies have shown these drugs have no therapeutic effect, but do have such side effects as drowsiness and dizziness which may result in accidents. The New York Acadamy of Medicine concluded that antihistamines have "no value in the treatment of true colds."

PJR

C. H. BARNETT and A. T. RICHARDSON, "The Postural Functin of the Popliteus Muscle," *Annals of Physical Medicine*, I:177-179, January, 1953.

Electromyographic studies demonstrated the action of the popliteus muscle as a medial rotator of the tibia on the femur. Some activity at the start of flexion of the knee probably can be correlated with the unlocking of the knee joint. In a crouching posture the muscle demonstrated continuous motor unit activity. When the knee is bent the weight of the body is directed along the shaft of the femur and there is a tendency for the femoral condyles to slide forward upon the tibial plateau. The posterior cruciate ligament is generally credited with resisting this subluxation, but it appears that it has the active support of the popliteus to stabilize the knee in this position.

PJR

K. MAHADEVA, R. PASSMORE and B. WOOLF, "Individual Variations in the Metabolic Cost of Standardized Exercises: The Effects of Food, Age, Sex and Race." *The Journal of Physiology*, 121:225-231, 28 August 1953.

We have a good body of data on the subject of body size, age, sex and race in relation to B.M.R.'s, but there is little data on the effect of these factors on metabolism during muscular exercise. In the present investigation the energy expenditure of fifty persons was studied during a step test and during walking. Results indicate that in any physical activity in which a large proportion of energy expenditure is used to move the body weight. Factors such as age, sex, surface area, race, and previous dietary, which are known to play an important part in determining individual basal metabolic rates, do not assume sufficient importance to add to the precision in assessing the cost of such activities.

PJR

C. DeWITT DAWSON, "An Intensive Exercise Program for Use in Knee Surgery and Pathology," *Archives of Physical Medicine and Rehabilitation* XXXIV:750-755, December, 1953.

The hinge function of the knee is accompanied by external rotation in flexion, internal rotation in extension. The knee is held in any desired position by the articular capsule with

tendinous reinforcements, the ligaments and the menisci. The quardriceps, biceps femoris, hamstrings, gracilis, sartorious, plantaris and popliteus stabalize and effect all joint movements. The condition of the medialis largely determines the "strong" or "weak" knee. If the joint is immobilized, abnormal changes occur in the quadriceps within twenty four hours. As the purpose of exercise therapy before and after operation is the prevention of or recovery from muscle atrophy and to increase joint function, the method of DeLorme is followed, using maximum resistance and low repetitions. Heavy resistance exercise is prescribed three days a week on alternate days; stationary bicycle riding, knee bends and active leg exercises are used on the other days for endurance and joint range increase. Hydrogymastics are excellent for post operative patients. The patient is encouraged to do 100-150 deep knee bends at home indefinitely. With this program earlier, more complete and less painful recovery and earlier discharge from hospital care is achieved.

PJR

N. P. SMITH, "Some Ideas and Suggestions on One Hand Typing," *The Crippled Child*, Vol. 31, No. 5, 20-23, Feb., 1954.

Many typing teachers have been working under the impression that a one hand typist must have a totally new and different system. Others advocate the use of a special keyboard which in itself is a disadvantage because of the possibility of a breakdown. Many employers hesitate to hire a person who cannot use the conventional tools of his trade. A system developed by Lilliam Blitzer does away with most of the misconceptions about one hand typing. Miss Blitzer's system is not radically different but utilizes two home positions which differ only slightly from those used in bimanual typing. With this system normal teaching devices may be used and no special equipment is necessary. Some patients may find it feasible to operate the shift and space bar with the other hand if sufficient function remains. Many patients will find that it is not inefficient to use the shift lock with the operating hand.

The home positions for left hand typing are: left-home position A S D F, right-home position, H J K L. These positions delegate a minimum of work to the little finger. It is well to cover the A and H keys with some tactile stimuli which serve as a nonvisual identification. In righ hand typing the nonvisual cues should be placed on the semicolon and G keys. The right-home position is, ; L K J, and the left-home position is G F D S.

Rhythm must be stressed. After practicing some exercises which develop rhythm, the patient is ready to proceed with any good typing manual. The use of special techniques and equipment is excusable only as long as the individual is inadequate in handling those in ordinary use. Crippled persons do not live in a special world and the less need they acquire for special considerations the less handicapped they will be.

T.A.W.
TAW

JOHN W. BROWN et al, "Final Report of the University of Wisconsin Atheltic Board to the Faculty Concerning Boxing as a Collegiate Sport," *University of Wisconsin Document* 1066, January 5, 1953.

During the years 1949-1952 inclusive the Department of Preventive Medicine and Student Health at the University of Wisconsin conducted a study of the medical aspect of intercollegiate boxing. Included in the methods used were the electroencephalogram and psychometric testing. These medical studies provided no justification for discontinuing the sport and the Athletic Board unanimously concluded that boxing as a colegiate sport as presently conducted should be continued.

PJR

W. B. SPAULDING, "Fatigue—Its Clinical Significance," *The Canadian Medical Journal*, 69:570-576, December, 1953.

As used clinically, fatigue is a *feeling* of difficulty in doing things. In the analysis of fatigue the following data should be obtained: What sort of sensation the patient is trying to de scribe; the mode of onset; the duration; the constancy and progression of the symptoms; the time of daily maximal intensity; precipitating and relieving factors; sleep; emotionally upsetting circumstances; accompany symptoms. There can be no short cut to the understanding of obscure fatigue. To determine the real cause one must know the patient well—his temperament and his personal circumstances as well as the structural defects if such there be.

PJR

LAWRENCE H. WISHAM, ARTHUR S. ABRAMSON, and ALFRED EBEL. "Value of Exercise in Peripheral Arterial Disease," *J.A.M.A.*, 153:10-12, September 5, 1953.

The question has been raised do exercises in the form described by Buerger and modified by Allen actually produce an increased blood flow in the extremities of persons with and without peripheral arterial disease?

Tested were 10 normal subjects and 19 patients who had arterial disease of the lower extremities. An amount of 0.1 cc isotonic sodium chloride containing radiosodium (Na^{24}) was injected into the belly of the gastrocnemius muscle. The rate of clearance of radiosodium from the tissues was measured during exercise and five minutes after cessation of exercise with the aid of a light weight Geiger counter strapped to the leg at the site of the injection. The subjects performed three forms of exercises.

Exercise No. 1: With the subject supine the leg was elevated to 60 degree angle and held for two minutes followed by leg in dependent position for three minutes and then leg in horizontal position for five minutes. Exercise No. 2: Same as 1 except active plantar and dorsal flexion of the foot was performed thirty times a minute while the leg was in the elevated and dependent positions. Exercise No. 3: With the subject supine, therapist exerted considerable manual resistance to active plantar flexion at the rate of thirty times a minutes for twenty minutes. Active dorsal flexion was unopposed.

Average increased bloodflow over resting rate was for:

A. Normal: During exercise 1, 33% and five minutes afterwards 7%.

During exercise 2, 63% and five minutes afterwards 17%.

During exercise 3, 114% and five minutes afterwards 41%.

B. Patients: During exercise 1, 17% and five minutes afterwards 8.7%.

During exercise 2, 34% and five minutes afterwards 23%.

During exercise 3, 84% and five minutes afterwards 47%.

The probable mechanism is through the mediation of vasodilator metabolites produced by the exercise.

JT

REMOVABLE ARE RESTS—

(Continued from Page 81)

the nature of the current arm rests. A specific example is presented and the problems related to the support of forearm, wrist and hand are cited. Also considered are problems related to support and posture in reversing the desk arm rest as recommended.

Finally the plans for construction and illustrations of the extension are set forth with the correction of certain specific problems related to a particular post polio patient with severe upper extremity and trunk involvement.

Conclusions:

After extensive experience in a pilot situation it is concluded that the removable extension arm rest is:

(1) A preventive measure against further deformity.
(2) A method of giving the patient support.
(3) Simple to attach.
(4) Easy to construct.
(5) A useful adjunct in furthering the therapeutic aims by combining the advantages of the desk arm rest and the standard arm rest.

Acknowledgement:

The authors wish to express their appreciation to the Medical Illustrations Section, Veterans Administration Hospital, Long Beach, California for photographic illustration.

Editorials

THE ROAD AHEAD

Any look into the future must review the accomplishments of the past. This brings into focus the direction to take for both the present and the future. There have been but few detours in the short life of this actively growing Association.

The accomplishments of the past eight years show steady gains. They show a steadfastness of purpose in developing adequate educational standards and training opportunities; a recognized professional Journal and a shifting emphasis from the scientific paper type of conference to the well-balanced combination of the scientific paper and the clinical demonstration and exhibit. This has brought together the leaders from medicine, industry and physical education in the panel type of discussion centered upon cooperative and coordinated action in the employment of the disabled. We look ahead to similar conferences with the psychiatrists and orthopedists, two disciplines vitally concerned with the rehabilitation of the disabled.

During this time the Association has become incorporated in the State of New York as a non-profit Association with headquarters in New York City. The American Board for Certification of Corrective Therapists has been put into operation. The Constitution and By-laws has been revised. A Code of Ethics has been developed and a new Technical Bulletin for Corrective Therapy has been published.

As we prepare for the Eighth Annual Conference and start planning the routes to travel, let us all recognize, that the first test of the Association's growth is the maintenance of the gains of the past. A constantly vitalized professional interest and spirit leading to increased membership calls for full speed ahead on the main highway.

Another road that beckons, is to supply the demand for more adequately trained therapists. Our successful work with the disabled, has been convincing evidence of the need for more therapists, not only in Corrective Therapy, but also in other ancillary therapies as well. The disabled are increasing as our population grows older. The demand for therapists will increase. More training opportunities will need to be provided. More students of physical education will need to be interested in the remedial and health maintenance phase of physical education. Many more schools of physical education with opportunities for clinical training will have to be interested in establishing courses for the Exercise Therapist.

A professional Journal with a professional content enriched and expanded, so that it is professionally stimulating to the increasing number of ancillary therapies engaged in rehabilitation should travel on a well marked highway, even though at times the grades may be steep.

The Association has never lost direction in its determination to make a real contribution to the ever expanding field of restorative medicine or physical and mental rehabilitation. Nor has it failed to accept guidance in its efforts towards acceptance as one of the necessary ancillary therapies, in the increasing national problem of mental rehabilitation. During its brief history of acceptable accomplishment, it has never looked with covetous eyes upon the work of any of the ancillary therapies. At no time has this been necessary nor will it be necessary, in the foreseeable future, with the demand for well-trained therapists so far exceeding the supply.

We are soon to assemble in Convention at Cleveland, Ohio. Some of the roads will be rough, challenging alertness. Others will be smooth and dull our senses. As we meet in the Representative Assembly, to mark the roads ahead for the ninth year of our Association, with the many items of business to be transacted, let us not become so involved in controversy that we lose sight of the road ahead. It is an open and challenging road, with but an occasional detour, which soon leads back to the main highway. The road ahead should be one of continued professional accomplishment.

THE PRESCRIPTION

(EDITOR'S NOTE: *Taken from the Southeastern Chapter Newsletter, March,* 1954).

In the days prior to our present specialization, the country doctor saw his patient, took his own history, did the physical examination, made the diagnosis and prescribed the treatment. In his treatment, he gave the details of his specific prescription for all services as crutch walking, general reconditioning and tonic exercise program to improve the patient's general mental condition, and all other services necessary to speed recovery. The only thing that was accomplished by other than himself was the special medications indicated, which was compounded in the local pharmacy by a licensed individual, according to the doctor's prescription.

This auxiliary person, the pharmacist, knew his Materia Medica, pharmacology and the art of proper methods of compounding. He took pride in handing to the patient or his family a package which was correct to the last detail. It was his pride to understand

the doctor's desires and to know that what he passed over the counter was precisely the exact order of the prescribing physician. No halfway measures were satisfactory. The dose was correct, the drugs were those specifically prescribed, and the mixture or powder had no incompatibles. He took pride in his job, in his store, and in his end result. It was a story of complete, thoroughly, precise close relationships between the doctor, the patient and the druggist.

Today, we are highly specialized. Today, the pharmacist has become a druggist with many types of merchandise occupying his time and his shelves, and many of the prescriptions go elsewhere than to the pharmacy. A prescription may go to the shoe man to fit a shoe for specific reconstructive work. A prescription may go to the brace man to correct or prevent deformity or to support a mal functioning area, or to many of the several specialized therapists. The druggist, the shoe man, the brace man, or any other, all fill prescriptions for material aids to the recovery of a patient.

To these long used prescriptions for drugs and articles, we have now added a newer one—a prescription for service. A prescription goes to the various departments of the Physical Medicine and Rehabilitation Service for their particular service to make the most of what the individual has left.

All these prescriptions going to the various specialties require that the therapist getting that prescription must understand his specialty and then with the same pride and thoroughness long shown by the druggist and artisans produce a finished product. Just as the pharmacist passed a package over the counter, the therapist passes to the patient a service. Where the druggist turned over a finished product, so the therapist should turn over to the community his finished work—a patient who has achieved maximum rehabilitation.

No therapist should be satisfied to call a case completed until he is assured that he has achieved the best possible result. With our knowledge of Anatomy, Physiology, Pathology and Kinesiology, we must expect a good deal more than frequently is attained. Our prescription gives us the objective, the starting point of our program, the time we have to accomplish our goal and whatever else may help us in treating the patient. From here the therapist takes over, tests the correctness of the base line data and figures out his problems. He then proceeds with complete understanding of the necessity for cooperation in treating the patient as a whole. From then on, the patient should show steady progress. If he does not show progress, further consultations with the prescribing physician are necessary or a further check on the techniques used in attaining the objective must be analyzed. Ordinarily, as with the druggist, the shoemaker or the brace man, this would be sufficient for good results. However, as specialists in a specific therapy, we are not producing an article but improving a person. Our aim is for the best possible result for each individual patient. For instance, to crutch walk is not enough. The crutch walker must understand the type of crutch walking he is to do, that is the best gait for him, and that he expends the least amount of effort in this specific gait.

When we get a prescription for our service to a patient, we must understand what is wanted by the prescribing physician and then attempt to attain as near normal function as is possible for that particular patient. We know that best results can only be obtained by closest cooperation with other departments whose prescriptions like ours have but one goal—the maximum rehabilitation of an individual. Then and only then have we achieved the goal of a specialized type of prescribed therapy. This should be what a prescription means to us.

S. S. Zintch, M. D., Chief P.M.R.S.
V.A. Hospital, Augusta, Georgia

AAHPER 1885-1957

"Yesterday, Today, and Tomorrow" is the title of an interesting pictorial review of the past, present, and future, of the activities and growth of the American Association for Health, Physical Education and Recreation, appearing in the April issue of their Journal.

It is interesting to note how the pioneers of the Association *were among the first to adapt physical education to fit the needs of the individual.* This bit of "earliana" in health, physical education and recreation, should serve to renew our confidence in the past, our belief and the dynamism of the present and challenge us to greater effort and confidence in the future of exercise in its varied and adaptable forms, as a necessary therapeutic agent, in the rapidly expanding field of restorative medicine.

(Editorials Continued on Page 99)

LIBRARIES: REQUESTING EARLY ISSUES

The Association will pay 75c for the following issues:

May-June-July-November	1947
Jan.-Mar.-Aug.-Oct.	1948
Feb.-April-June-August	1949
Feb.-April	1950

February 1950 urgently needed.

RESEARCH

(EDITOR'S NOTE: *This is the third and last in a series of hypothetical conversations between an inquiring Corrective Therapist and a "Research Counselor."*)

PART III.—METHODS OF OBTAINING ANALYZING, PRESENTING, AND EVALUATING DATA IN A RESEARCH STUDY

Q. *Do you have suggestions as to the most feasible types of data to obtain in a research investigation? Also, what are some of the acceptable ways to obtain the data?*

A. Ordinarily it is better to obtain quantitative or numerical rather than qualitative measurements of the variables being studied. In this way standardized statistical techniques can be more readily applied and the results will have a higher degree of objectivity. Also, they can be more easily valuated or reproduced by other research workers interested in that particular problem. This is not to rule out, however, the use of qualitative (or non-metrical) measurement in certain situations where the variables do not lend themselves to quantification, or where if quantification is attempted they lose some of their richness or original meaning. A sort of compromise measurement technique which is often profitably employed is the rating scale, which assigns more or less equal units along a continuum that is otherwise not generally regarded as especially quantifiable. For instance, persons can be rated on a scale from "very artistic" to "not at all artistic." The chief weakness in qualitative measurement is that, as implied above, the results are less objective and carry a heavier "intuitive" element, which in turn means greater difficulty in sharing or reproducing the results with other workers. There may be the same amount of "truth" or new and valid knowledge emerging, however, as with the quantitative approach; it is mainly that the results are more difficult to communicate, and the *odds* of yielding non-valid conclusions are perhaps slightly greater.

Q. *Once you have obtained your data (or your measurements or scores) then what are the next steps?*

A. They should first of all be analyzed according to statistical principles appropriate to the experimental problem. And secondly, they should be presented in a manner which correctly represents the relationships which have been discovered in the analysis and in a manner which clearly communicates these relationships to the reader.

In anlyzing one's data, a statistics book is a must. Even though for many people they have all the preconceived attributes of a nightmare, some of the more recent volmues are actually quite palatable. Examples of lucid presentation of statistical principles are: Edwards, A. L. *Statistical Analysis,* 1946, and Garrett, H. E. *Statistics for Psychology and Education* (4th Ed.), 1953. A calculator is also most desirable, especially if one is dealing with a large number of scores. Most hospital installations will doubtless have calculators which can be made available to the interested researcher. Space prevents our elaborating on the types of analysis that are usually carried out in research projects. These can be found by consulting a statistics book. It should be added, however, that a good piece of research is one where, among other things, the worker has decided on the type of analysis to be used even before experiment proper (i.e. the data collecting) has commenced.

On the point of presentation of the data, it is suggested that liberal use of graphs be made. The chief purpose of graphs is to convey visually certain trends or relationships which are ideally expressed elsewhere either in tables or in the body of the text. The graph shows the sailient relationships for quick appraisal; the table, on the other, presents usually more detailed numerical evidence for closer, more prolonged study by the reader.

Q. *What are some of the things to keep in mind in evaluating the results of a piece of research:*

A. One point to consider is whether the results support or fail to support the original hypothesis. If they support the hypothesis, how does this new knowledge fit into or contribute to a broader theory in which it logically falls? If the results do not support the original hypothesis, they may have comparable significance to the extent that they point up weaknesses in the hypothesis itself, in the experimental design seeking to test the hypothesis, or indeed in certain aspects of the broader theory itself. We may increase our knowledge as much by demonstrating the invalidity of certain commonly accepted ideas as by uncovering new relationships. In evaluating our results, we should also exercise care not to generalize beyond the bounds that our data allow us to go. If we are studying a small, rather unique sample of subjects, we should not blandly draw conclusions for the population at large. Statistics texts also have quite a bit to say in this regard.

By way of a concluding remark, it is urged that

any research project be entered into thoughtfully and carefully. In some respects, the most important work is done before the first case is seen or the first score is obtained. After that it is primarily legwork—not "headwork."

EXPERIMENTAL WORK IN ANKYLOSING SPONDYLITIS

(EDITOR'S NOTE: *This summary of a study, in which the patients and therapists spent the day together, reports a type of controlled treatment that many therapists have hoped many times to accomplish. It will be reported in three issues. Experimental Work No. 1 is reported in this issue. These summaries have been submitted in appreciation for receiving reprints and an exchange subscription of our Journal with ACTA CHIRURGIAE ORTHOPAEDICAE ET TRAUMATOLOGIAE CHECHOSLOVACA, The Editor would be grateful if any of our readers can translate the sections of the articles that are not in English.*)

From the Clinic for the Study of Tuberculosis, Charles University Prague. Director Professor J. Jedlicka M.D.

From the Institute of Physiotherapy and Balneology, Charles University Prague. Director Professor Frant. Lenoch M.D.

From the Second Clinic of Orthopaedic and Children's Surgery, Charles University of Prague. Director Professor O. Hnevkovsky M.D.

THE USE OF THE DRINKER-COLLINS RESPIRATOR IN FUNCTIONAL INSUFFICIENCY OF THE LUNGS IN STRUMPELL-PIERRE MARIE-BECHTREW'S ANKYLOSING SPONDYLARTHRITIS

(VLIV POUZITI DRINKER-COLLINOVA RESPIRATORU NA FUNKCNI INSUFICIENCI PLIC U SPONDYLARTHRITIS ANKYLOPOETICA STRUMPELL-PIERRE MARIE-BECHTEREV)

EXPERIMENTAL WORK No 1

Dedicated to the 50th Birthday of Professor Otakar Hnevkovsky M.D.

By

Jiri KVACEK M.D., Prof. Frantisek LENOCH M.D., Ludmila NECHVATALOVA, Zdislava POLAKOVA M.D., Jirina PROVAZNIKOVA, Petr TRUHLAR M.D., Miroslava ZAMOSTNA

SUMMARY

1. In ankylosing spondylitis the initial stage which is without X-ray changes may last for several years before X-ray changes can be ascertained.
2. In the costovertebral joints the fine X-ray changes are particularly difficult to detect and the period before the appearance of X-ray changes is particularly long.
3. The limitation or abolition of movement at these articulations results in a marked diminution in the extent of respiratory movements and finally to complete rigidity. This may occur before ankylosis of the joints and ossification of the ligaments can be seen on the film.
4. The extent of the limitation of respiratory movements can be roughly measured by the difference in the chest circumference in inspiration and expiration or by measuring vital capacity. The functional examination of the lungs is an exact method of assessing diminution in respiratory movement.
5. 12 cases of Strumpell-Pierre Marie-Bechterew's spondylitis were selected from among those under treatment for report in this paper. Not one of these patients had normal lung function as ascertained by global spirometry at the first examination.
6. Since it was wished to improve the method of treatment by active breathing exercises, in these 12 patients and attempt was made to complement active breathing exercises by passive movement using the Drinker-Collin respirator (Iron Lung).
7. This experiment was made over the period of one month only in order to ascertain whether assisting active breathing exercises by passive means was of benefit or harm to the patient.
8. The functional examination of the lungs before and after assisted breathing exercises showed an emprovement in 45, 4% of patients after 16 to 24 exercises.
   Where a deterioration of respiratory function was noted it was due in each case to improportionate hyperventilation. This deficiency can be obviated in the future by improved technique.
9. The follow up of the subjective, objective, functional and laboratory charges in the 12 patients (table 7) showed that the exercises had neither a harmful nor a beneficial effect on the inflammatory component of the disease. Both remission and progression of the inflammatory signs were noted during the course of the treatment. One patient only coplained by subjective deterioration. The rest felt better regardless of the ob jective, clinical, functional and laboratory results.
10. The authors consider that the assistance of active breathing exercises by the use of the Drinker-Collin respirator is a practical method of treating ankylosing spondylitis. It appears to be of more value than the methods previously used for the same purpose. It will be necessary to elaborate the method further on the basis of the experience already obtained and it is hoped that the results will be further improved by using the method over longer periods.

ACTA CHIRURGIAE ORTHOPAEDICAE ET TRAUMATOLOGIAE CECHOSLOVACA Annus XVIII, Ordinis novi II, Numerus 5-7, 1951, pp. 184-194

Book Reviews

PHYSICAL MEDICINE AND REHABILITATION, Edited by Basil Kiernander, M.B., B.S., M.R.C.P., D.M.R.E., D.Phys.Med., Charles C. Thomas, Springfield, Ill. 609 pp., $12.75, 1953.

The editor is eminently qualified to edit this comprehensive text. This book contains contributions from 22 English and Canadian specialists in Physical Medicine and related fields. Contributions by four well known American authors show the effort made to make this book one of outstanding value to the field of restorative medicine.

The first four chapters give consideration to the basic sciences, upon which good techniques in physical medicine and rehabilitation are built. Chapter I devotes 90 pages to a review of the Functional Anatomy of the Locomotor System. In Chapter II a practical approach has emphasized "the effects of exercise on the body and presented the physiology of clinical conditions which affect freedom of movement." In Chapter III the author, in analyzing the problem, gives a picture of the factors influencing the patient in the hospital. He speaks of the training of the doctor which has "resulted in assessing the patient's disability and not the patient's capabilities as a whole." This author would have the patient, "once he is out of bed, spend the whole day" in the Physical Medicine and Rehabilitation Department. The outline of a patient's programme appearing in this chapter shows the special emphasis being placed on getting the patient back to employment. A table showing how groups of patients are treated by the Remedial Gymnast—who corresponds to the Corrective Therapist in this country—indicates that active exercise is being used very extensively. Writing on the Remedial Gymnast in this third chapter, the author says, "The enlightened remedial gymnast is also a very important cog in this machine. He also should be a man of enthusiasm, well versed in his art and have a good training in anatomy and physiology, but above all he must be an enthusiast because his work is arduous and exacting. He must give of his personality during the whole of his working hours. His cheerful understanding demeanor encourages his sometimes unwilling patients to do their remedial tasks. His program should be a nice balance between the direct and indirect attack upon the injury. He should be able to eliminate the boredom and fatigue by switching from direct remedial exercises to indirect remedial games. He should, above all, have a feeling for rhythm and music because this understanding of rhythm prevents the earlier onset of fatigue."

Chapter VI under the joint authorship of a doctor of physical medicine; a consulting orthopaedic surgeon, and the director of a rehabilitation center in England, presents a philosophy based upon the oft used quotation of John Galsworthy, "A niche of usefulness and self-respect exists for every man, however handicapped." This philosophy is based on a period of reconstruction and another of recovery with emphasis placed upon starting recovery as soon as active exercise is possible. A technique for accomplishing recovery is based upon "grouping in terms of joints, with grading into, early, intermediate and late stages, according to degree of recovery that has been reached, has been found a convenient but workable plan, e.g., (a) shoulder, (b) elbow, (c) spine, (d) hip and knee, (e) ankle and foot." Specific objectives are determined in each phase and treatment would seem to be more standardized under the English and Canadian plan, than in this country.

An excellent chapter on The Place of Physical Medicine in Geriatric Rehabilitation, places emphasis on making full use of conditioned reflexes to secure competence in the self-care activities such as "getting into and out of bed, eating meals, putting on clothes, going to toilet, and other essential parts of functional rehabilitation." The author of this chapter concludes: "The aim of geriatric rehabilitation is to restore the maximum degree of painless movement by means of active physiotherapy, and remedial exercises, resulting in the maximum of personal independence; we can no longer be satisfied with merely removing pain. If the patient reaches a stage of weight bearing, assisted or unassisted, so much the better." . . . "No longer do we label our patients irremediable, incurable, chronic or senile; instead we make a prognosis based both on diagnosis and on the assessment of the particular person's physical capacities."

The remaining fifteen chapters deal with hemiplegia, vocational rehabilitation, physical methods of diagnosis and treatment of rheumatic diseases, joint manipulation, the application of physical medicine to pediatrics, dermatology, chest disorders, heart disease, vascular disorders, otolaryngo-rhinology, eye diseases, obstetrics and gynecology, psychosurgery, tuberculosis and venereal disease, indicating the scope of the subject matter contained, to sustain the editor's thesis "that Physical Medicine now has an important part to play in every branch of Medical Science and that all clinicians of the future will be expected to know the basic principles of this subject as it affects their clinical specialty.'"

This text is illustrated and should furnish excellent material for In-Service Training courses, as well as many evenings of pleasurable and informative reading for physiatrist and therapist alike.

BASIC PROBLEMS IN PSYCHIATRY, Editor, Joseph Wortis, M.D. Contributors, Joseph Wortis, M.D., and others. Cloth $4.50. Pp. 186, with 3 illustrations. Grune & Stratton, Inc., 381 Fourth Ave., New York 16, 1953.

This readable little book is an outgrowth of a lecture series for the house staff and community physicians, given at the Jewish Hospital of Brooklyn. The six contributors and the editor, all qualified psychiatrists and psychologists, bring from their varied clinical and research experiences a critique of present day psychiatry. W. Horsley Gantt summarizes the results of Pavlovian conditioned reflex experiments. Paul Hoch compares the various "schools" of psychiatry. Other authors discuss the influence of culture, the validity of psychological tests, the choice of psychosomatic symptoms, and the limitations of psychiatry. The result is somewhat uneven and definitely individualistic. Two contributors append a bibliography. The book might be considered a minority report aimed at the complacency of those who believe that psychiatry already knows most of the answers. The plea of the editor is for a common sense approach based on data verifiable in the laboratory. Psychiatrists will find the book interesting and provocative.

THE PHILOSOPHY OF PSYCHIATRY, by Harold Palmer. New York: Philosophical Library, 1952. $2.75.

Attempts to delineate the subject matter of psychiatry, Palmer writes, are hampered by elementary problems of communication. The purpose of this little book is to define the meaning of terms which the writer commonly employs. He first defines twelve assumptions on which he believes the theory and practice of psychiatry rest, then the "primary," (mechanism and individuation), "secondary," (environment and teleology) and "clinical" (classification and treatment) "entities" of psychiatry. It is claiming too much to contend this is a philosophy of psychiatry. Is there, indeed, any such thing? Many would argue that our philosophy determines our view towards psychiatry and that there is no such thing as a philosophy of this or that. *The Philosophy of Psychiatry* is actually a semantic study, and certain of the author's basic assumptions might be phrased quite otherwise by men of a different philosophical bent. It is unfortunately true that psychiatry has been split into numerous schools, with wide variations in therapeutic practice resulting therefrom. If Palmer's book results in each school examining just what it means by the terms it employs and defining with some exactness what in its view constitutes the subject matter of psychiatry it would do much to restore order in an area which is now largely chaotic. In such case the author would probably feel that he had accomplished that which he had set out to do. PJR

TECHNIQUES OF ATHLETIC TRAINING, by Gene A. Logan and Roland F. Logan. Los Angeles: Franklin-Adams Press, 1952. 138 pages plus index. $3.50 (Paper).

The word "Training" in the title of this book refers to the treatment of athletic injuries, and that principally by taping. It is the best and most lavishly illustrated manual on this subject that the reviewer has ever seen. Three or four large drawings per page, totalling over 400 in all, and short, clear accompanying directions make this a guide that even an inexperienced trainer can follow with ease. Directions start with the feet and move upward, covering the entire body in the process.

There are sections devoted to training room layout, some anatomy charts, and some general directions regarding the handling of certain pathological conditions. The Logans' book is highly recommended to anyone who has a need for a knowledge of the art of taping. PJR

THE ANATOMY OF THE NERVOUS SYSTEM—ITS DEVELOPMENT AND FUNCTION, by Stephen Walter Ranson, Revised by Sam Lillard Clark, M.D., Ph.D. 9th Ed. W. B. Saunders Company, Philadelphia, 1953. 581 pp. $8.50.

Ever since Dr. Ranson's "ANATOMY OF THE NERVOUS SYSTEM," was published in 1920, it has been the favorite textbook in the field. It has become almost a classic. Dr. Stephen Walter Ranson, 1880-1942, held the position of Professor of Anatomy at Northwestern University Medical School for forty years, and later he became director of its institute of Neurology. Of his continuous series of contributions to the field of neurology, his unsurpassed textbook, "ANATOMY OF THE NERVOUS SYSTEM" is the most outstanding. Each successive edition engaged Dr. Ranson's most careful attention. The Eighth and Ninth Editions were prepared after his death by his former pupil, Sam Lillard Clark, Professor of Anatomy at the Vanderbilt University School of Medicine, Nashville. It is brought up-to-date, and includes the most recent information such as a discussion on inhibiting and facilitating mechanisms of the brain stem, and also reflects our advancing knowledge of the cerebellum.

Throughout the text, structural description is blended with functional outline. The book contains a wealth of clear illustrations, a beautiful atlas of sections of the brain, a laboratory outline of neuroanatomy, and a chapter of clinical illustrations integrating anatomical data with characteristic neurological case histories.

All this should be of value to the teacher and student alike, and will contribute to guarantee this textbook its continued popularity. EF

PERIPHERAL NERVE INJURIES, by Haymaker, Webb, and Woodhall, Barnes. W. B. Saunders Company, 1953. Pp. 333, with 272 illustrations. Second edition. $7.00.

This is the second edition of a very popular and well written book on a timely subject, namely traumatic nerve injuries. The recent Korean conflict has given impetus to a re-writing of this book. This monograph includes both normal anatomy as well as methods of recognizing dysfunction of the peripheral nerves.

The book is divided into four sections: the first deals with the principles of innervation, the second with examination of the patient, the third with a clinicopathological classification of peripheral nerve injuries and causes and the general symptomatology of such injuries, and the fourth with the clinical features of individual plexus and peripheral nerve injuries.

Excellent illustrations and photographs accompany the text plus numerous diagrams for clearer understanding of the anatomy involved. Most of this material came from the Armed Forces Institute of Pathology. An up-to-date list of references is also included in the bibliography.

This monograph will serve well as a ready reference for those who come in contact with traumatic nerve injuries. As such, it is highly recommended to students and surgeons interested in traumatic cases. JGD

CABLE-TENSION STRENGTH TESTS, by H. Harrison Clarke, Chicopee: Brown-Murphy Co., 1953. 31 pp. (Paper, spiral bound.)

JOURNAL readers will recall that the April-May, 1950, issue contained an article on "Strength Curves for Fourteen Joint Movements," by Clarke and Bailey. The present booklet records the full development of the techniques described therein. The anatomical positions for the greatest application of pulling force for 38 joints are described. Written directions and accompanying drawings clearly explain the techniques employed. Actual measurements are read from a slightly modified aircraft tensiometer. The system appears to be both objective and simple to use. It is believed that it would prove satisfactory in nearly any situation where it is desired to measure the strength of muscle groups. PJR

THE MAKING OF A MORON, by Niall Brennan, New York: Sheed and Ward, 1953. 189 pp. $2.50.

"To enter a spinning-cotton or other factory," wrote Schopenhauer, "and from that time for to sit there daily . . . performing the same mechanical labor is to purchase dearly the satisfaction of drawing breath. But this is the fate of millions and that of millions more is analagous to it." "And," Mr. Brennan would add, "it makes morons of them." Brennan, an Australian journalist, became disturbed over experiments showing that morons could perform many of the operations of industry just as well, or even better, than could normal employees. Does this mean, he asked, that in such operations the normal is actually pulled down to the level of the subnormal? His answer is affirmative. Experience in a great number of types of work has convinced him that industrial efficiency pursued as a means of material wealth without reference to moral means is harmful to the nature of man. A lunatic, he says, is a person out of line with reality; when a man comes to believe that money is the most desirable thing in the world, he becomes a lunatic. The key to the moronising effect of contemporary work is its frustration of the worker.

This is frankly polemical and we need not accept such logic as, "—a brief survey of a 'popular' bookshop or newspaper-stall will revolt anyone of normal intelligence. Those who are not revolted by it are not of normal intelligence." Much of it has been said before, particularly by Veblen. But in essence it well describes the plight of the average man as he leads his life of quiet desperation. It is interesteing reading and one wonders how far the conditions he describes are responsible for our over-flowing mental hospitals.

PJR

DR. PYGMALION, by Maxwell Maltz, M.D., New York: Thomas Y. Crowell Co. 1953, 261 pp., $3.50.

What might otherwise be considered subject matter of less than general interest, becomes in the hands of Dr. Maltz a warmly human document that must surely bring hope to those in need of a "Dr. Pygmalion".

Written in autobiographical form the volume is a skillful blend of Dr. Maltz' personal and professional history, comprising also a goodly amount of technical material concerning plastic surgery. The latter becomes infinitely more understandable to the lay person by reason of its presentation in terms of human equations and needs.

Historical data incorporated into the text is enhanced and its reader interest hightened by inclusion of gentle satire.

The author's presentation of his patients and situations in which they become mutually involved conveys to the reader a feeling that Dr. Maltz' healing hands treat of more than visible scars and disfigurements. This salient factor of Dr. Maltz' story becomes doubly effective because never is a concerted effort made to make this point impressive.

The reviewer unequivocally recommends this splendid human experience and hopes that soon we may hear more of "Dr. Pygmalion."

IF

WRESTLING, by E. C. Gallagher and Rex Peery, New York: A. S. Barnes and Company, 1951. 91 pp. $1.75.

This reviewer has long felt that wrestling is a much neglected subject in the rehabilitation field. It is perhaps the only sport in which the blind can compete with the sighted on nearly equal terms, it is an excellent body builder, knowledge of its techniques inspires confidence in the timid and both the aggressive and the homosexual patients may use it to meet their needs in a socially acceptable way. The Corrective Therapist whose knowledge of sport is insufficient for him to teach it will find this little volume an excelent aid. If not as detailed as some of the other manuals, neither is it as expensive. At the price you can't match it.

Essentially the book is a revision—and a good one—by Rex Peery, wrestling coach at the University of Pittsburgh, of Gallagher's *Wrestling*. The material has been modified to conform to present rules and trends. By making each picture half the size of those in the Gallagher edition, Peery has included twice as many illustrations. Brief chapters on the history of wrestling, training and conditioning and a glossary have been added. The general arrangement of the technical chapters has been left unchanged. In these days of high prices the text represents an excellent value.

PJR

THE ENCYCLOPEDIA OF SPORTS, by Frank G. Menke. New and Revised Edition. New York: A. S. Barnes and Company, 1953. 1018 pp. $10.00.

The present theory of Corrective Therapy holds that interpersonal relationships are more important than the activity *per se*. In a C. T. gym discussion of athletics is a natural and easy way to start the formation of the desired relationships. For furnishing topics or settling arguments arising from them, Menke's *Encyclopedia* is THE book, and this new and major revision is the finest issue yet. The material has been largely rewritten and rearranged, as well as brought up to date. Much new data, such as the list of "The Ring's" Merit Award winners and diagrams of important stadia have been added, while material of doubtful value, such as dominoes and lotteries, has been deleted. Humorous cartoons by Willard Mullin head up many sections. The index has for the first time been made a useful working tool; in brief, the whole book is vastly improved.

The weaknesses evident are those which have characterized the previous editions. There is still no listing of the selections of the All America Board of Football, although on the West Coast, at least, the players themselves for years considered this the team they most desired to make. The Mid-Century A. A. does not seem to be included. The sections on weightlifting and on wrestling are poor. There is still no information on the Mr. Americas and the Miss Americas. The lists of athletes prominent in a given sport or who did not make all star teams have no apparent utility. As it seems unlikely that major changes in format or arrangement will again be necessary, perhaps the author can devote attention to eliminating these weaknesses in future editions.

The price may prove a deterrent to many, but this is a big book and quite the best thing that has been done in its field. For public institutions and for athletes and fans who can spare the money it is a must. PJR

THE TWENTY-SECOND ANNUAL SURVEY OF FOOTBALL FATALITIES, by Floyd R. Eastwood *et al.* Los Angeles: Los Angeles State College, 1954. 25 pp. (Hectographed.) Free.

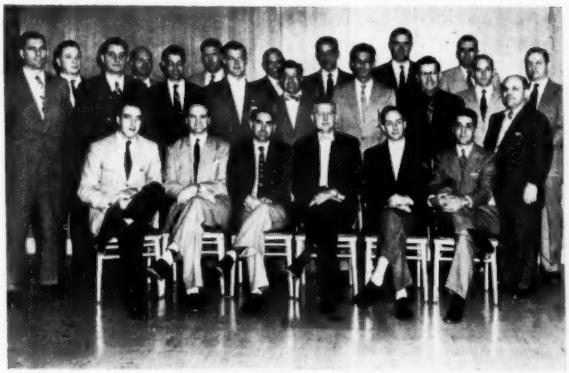
These annual surveys continue to be required reading for anyone concerned with athletic injuries. Nineteen football fatalities were reported in 1953. Over the past 22 years 49% of the direct fatalities resulted from head injuries. Evidence indicates that the top of the head and the back of the head need the greatest protection. The Committee recommends that "a separate and distinct study be made on types of materials useable for shell liners and as well as the type and kind of suspension most suitable for safety." It also stresses the great importance of vigorous warm up periods *immediately* preceding the first and third periods and before a player enters the game. The Committee states "Inadequate warm-up is a more important contributing cause [to injuries] than is fatigue." The importance of proper headgear and thorough warm up has been stressed by the Committee year after year. One wonders how long players are going to continue to be needlessly injured before the powers that be do something to implement their recommendations. PJR

KNOTS, SPLICES AND ROPE WORK, by A. Hayatt Verrill and E. Armitage McCann. New York: The Norman W. Henley Publishing Co., 1946. 146 pp. Cloth edition $2.00; Paper, $1.50.

The Corrective Therapist working in a socialization clinic may find it advantageous to know something of plaiting, knotting and scrimshaw work in order to assist his patients in making belts, table cloths and other items. Unfortunately, this pocket sized manual seems designed primarily for yachtsmen. It contains numerous drawings and descriptions of knots suitable for shipboard use, but very little of the fancy work which alone would be of professional use to the therapist. Those who are fortunate enough to own boats will find it a handy guide to its subject. PJR

Chapter Activities

MIDDLE ATLANTIC STATES CHAPTER



Seated, l to r—W. E. Cully, Micheal Yarosh, Francis Marusak, Dr. Dwight L. Moyer, B. A. Peckerman, Frank Delliquanti. Standing, l to r—Joseph Lapiana, Edward Walsh, E. Blender, John Delmar, Robert Cypress, E. T. Pendelton, Vic Mayer, E. W. Weber, John Cerra, Lansing Hills, M. Gerko, William Capallo, Vivian McGrath, V. W. Horley, Frank Carroll, F. Chilletti, Charles Carrol.

Pictured above are members of the Middle Atlantic States Association for Physical and Mental Rehabilitation who attended the recent conference at the Veterans Administration Hospital, Wilkes-Babbe, Pennsylvania.

Michael Yarosh, Chief of Corrective Therapy at the local VA Hospital, was in charge of the meeting.

The program included: Invocation by Chaplain Thomas A. Hiznay; address of welcome by Dr. John W. Walsh, Chief of Professional Services ,and an interesting talk on the history of Corrective Therapy was given by Dr. M. Herbert Fineberg, Manager of the Hospital. Dr. Fineberg stated that "Corrective Therapy was one of the forms of treatment introduced by Dr. Simon Baruch, father of the eminent Bernard Baruch at the Montefiore Hospital, New York City, early in the present century and that it was not until World War II that this type of treatment was given a great impetus. In the Armed Forces it developed rapidly to meet the increased need in the total rehabilitation of the patient. Prescribed exercises and adjunct treatment methods aid in the physical and mental rehabilitation of the patient. We all feel that our Hospital has an excellent Corrective Therapy Department which is of great help in securing the maximum degree of patient rehabilitation.

The chapter president, Frank Marusak, Chief of Corrective Therapy at the VA Hospital, Perry Point, Maryland, thanked Dr. Fineberg for the many courtesies extended by the Hospital as host for the conference.

Dr. Dwight Moyer, Chief of Physical Medicine Rehabilitation Service, commented upon the effective results obtained in this field and attributed the results to the diligent work in the specialized area of Physical Medicine and Rehabilitation.

Mr. Charles Scully, Area Field Representative, Physical Medicine Rehabilitation Service VA Center Office, Washington, D. C., stated that Exercise Therapy is well established in VA Hospitals in the United States and programs are being developed in the VVA Hospitals of Puerto Rico.

Dr. N. Konecke and Michael Yarosh, presented the case of a severely handicapped World War I patient who has been unemployed and in and out of hospitals for the past 36 years, wearing braces on both lower extremities and confiened to a wheel chair. The work renedered by the Rehabilitation Service enabled the patient to leave the hospital walking with crutches. One brace was eliminated and he no longer required a wheel

chair. A new shoe was designed for the patient which immeasurably improved his walking technique as well.

Frank Delliquanti, Exercise Therapist, VA Hospital Wilmington, Delaware, also portrayed the case of a geriatric patient for whom ambulation was all but given up. Through carefully graduated resistive exercises the patient was able to develop musculature to enable him to ambulate independent of assistance.

Charles D. Karoll, Assistant Chief, Corrective Therapy, assisted by Exercise Therapist, Edward P. Walsh gave a demonstration and explanation of the various treatment techniques and, modification of equipment used in the field of Corrective Therapy. The equipment was especially adapted for the use of patients affected by hemiplegia, multiple sclerosis, amputee, neurological patients and orthopedic patients.

Michael Gerko, Exercise Therapist, VA Hospital, Richmond, Va., summarized the feeling of the conference by stating, "If I were a patient in this hospital with its modern equipment and beautiful environment, I could immediately look forward to becoming well."

A business meeting was held at the close of the conference and was followed by a social hour at the American Legion Home, Kingston, Pa.

The next meeting of the chapter will be May 22 at Coatesville, Pa.

Not included in the photo but attending the conference were: Dr. M. Herbert Fineberg, Manager, VA Hospital, Wilkes-Barre; Dr. John W. Walsh, Chief of Professional Services; Dr. M. Konecke, Neuropsychiatric Service; Anthony J. Kursvietis, Executive Assistant, Physical Medicine Rehabilitation Service; Charles W. Scully, Area Field Representative, Physical Medicine Rehabilitation Service, VA Area Office, Washington, D.C. and John G. Carr, Chief of Special Services.

TEXAS CHAPTER

The fourth Annual Meeting and Clinical Session of the Texas Chapter was held at the Medical Field Service School Fort Sam Houston, Texas on February 26-27, 1954. The conference was outstanding in all respects with the largest attendance in the history of the organization. The conference theme was: "Rehabilitation-Service Through Knowledge and Cooperation."

The clinical sessions featured outstanding speakers and panel discussions on pertinent subjects as: Psychological Aspects of Illness and Injury; Motivations for Recovery; Basic Physiology of the Nervous System; Use of Photography in Medical Rehabilitation; The Role of Corrective Therapy in the Treatment of the Permanently Disabled; Remedial Underwater Exercise Programs; Research in Rehabilitation; and other related subjects.

The Corrective Therapy group met with the Southern Section of the Congress of Physical Medicine for their Clinical Seminar on Saturday afternoon. Jack Tractir, one of our members from Houston, presented a paper on one of his research projects before this group.

A new constitution for the Chapter was adopted at the Friday night business meeting. The possibility of Houston being selected as the site for the 1956 Convention of the Association for Physical and Mental Rehabilitation was discussed. It was unanimously agreed that the Texas Chapter would strongly support this movement.

The 1955 annual meeting and clinical session of the Texas Chapter will be held in Houston.

An advisory Board for the Texas Chapter was selected with the following members: Dr. Oscar O. Selke, Hermann Hospital, Houston Texas; Lt. Col. John H. Kuitert, MC, Brooke Army Medical Center, Fort Sam Houston, Texas; Dr. Lewis A. Levitt, VAH, Houston, Texas; Dr. Roland S. Fillmore, VAH, Temple, Texas; Dr. T. W. Wade, VAH, Dallas, Texas.

Officers elected for the coming year are: President, John Arena, VAH, Houston, Texas; Vice-President, George D. Allen, VAH, McKinney, Texas; Secretary-Treasurer, Bill Holzaepfel, VAH, Houston, Texas.

Major Henry J. Rockstroth and his staff arranged a very pleasant schedule of social activities for the members and their wives. Major and Mrs. Rockstroh entertained with a buffet dinner at their home on Friday evening. A special luncheon was served the Texas Chapter and the Southern Section of the Congress of Physical Medicine at the MFSS Officers Club on Saturday noon. The climax of the conference was a cocktail party and banquet for both groups at the Gunter Hotel on Saturday night.

OHIO-KENTUCKY CHAPTER

The Ohio-Kentucky Chapter of the Association for Physical and Mental Rehabilitation held their March meeting at this hospital. The program was open to the Public and about 50 persons registered and attended. PMR members attended from VA hospitals in Dayton, Cleveland, Chillicathe, Louisville and persons from various other rehabilitation agencies and institutions.

Earl Raymer, President of the Chapter and 2 therapists attended from Crile VA in Cleveland. Art Landy, Chief of C.T., and about 10 others made the trip from Cillicothe. Worth Randall, Chief of C.T., and 2 others came from Dayton VA Center.

Harold Robinson, the National Association President, was able to attend and brought news of current events of the National Association. The September meeting will be held at the Lexington VA Hospital if possible.

Earl Raymer Chairman of the National Convention to be held in Cleveland this June, discussed the plans, program, and exhibits for that meeting.

KANSAS CHAPTER

The Kansas Chapter of Corrective Therapists met in Leavenworth, Kansas, Thursday March 4th. The meeting was in nature a business meeting: Election of officers for the coming year, Advisory Board, State Chapter constitution, etc. were the topics of the meeting.

The newly elected officers for the coming year are as follows:

President—James W. Watkins, C. T. Dept. Winter VA Hospital, Topeka, Kansas.

Vice-President—Larry Hientzleman, CT Dept. VA Center, Wadsworth, Kansas.

Secretary-Treasurer—Kenneth R. Evans, CT Dept. VA Center, Wadsworth, Kansas.

One member of the Advisory board to represent Wadsworth has been established. Dr. Radyzminsky PMRS chief at Wadsworth chosen and has accepted. The advisory board member for the Topeka group as yet has not been selected.

Drafts of the State chapter constitution placed in the hands of all members to study and revise. The group will vote on its adoption at the next Chapter meeting.

The group voted and passed upon a new name for the chapter. Hereafter the Kansas Chapter will be referred to as the "Heart of America Chapter."

Three new members were voted into the Chapter. Mr. Robert Retter, Wadsworth, Mr. Claude Daniels, Topeka, Mr. Kenneth R. Evans, Wadsworth.

Group discussion on Chapter affiliations and expansion rounded out the meeting. The incoming Secretary will probably keep you posted on the progress in this area as it develops.

MID-WEST CHAPTER

The sixth meeting of the Mid-West Chapter of the Association for Physical and Mental Rehabilitation was held at the new West Side V.A. Hospital Chicago, Illinois, on Saturday, March 27, 1954. The meeting was well attended with many out-lying hospitals sending at least one therapist. The session opened with an informative, inspiring talk by Dr. John E. Davis, Chief of Corrective Therapy, Washington, D. C. Dr. Davis explained and elaborated on the recently published Technical Bulletin which fully describes Corrective Therapy functions.

The President of the Mid-West Chapter, George E. Nash, VAC, Wood, Wisconsin, then called the business meeting to order. The most important business on the agenda was reorganization of the Mid-West Chapter, which was accomplished. The Mid-West Chapter is made up of Area No. 4 (Illinois, Michigan, Wisconsin Iowa, Minnesota, Nebraska, No. Dakota, Montana and Wyoming) and Missouri.

Later during the afternoon, reports on Certification and Membership were given by Harold M. Robinson, President of the Association and Chief of CT at Downey, Illinois and Leslie M. Root, Chief of CT at VAC Wood, Wisconsin.

Following the business meeting, Carl Purcell, Chief of CT at Hines, Illinois showed an excellent film entitled 'The Long Cane", which was filmed at the Blind Center Hines VA Hospital, Hines, Illinois. Immediately following the showing of the film, Florian Surdyk, Chief of CT at West Side VA Hospital, Chicago, Illinois, conducted the group on an informal tour of the Physical Medicine Section.

CODE OF ETHICS
ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION

(Editor's Note: The preliminary report of the work of the Committee on Ethics, is published at this time, so that the membership may have an opportunity to suggest constructive changes, when this important matter is brought before the Representative Assembly at the Cleveland Convention.

Active Members of the Association for Physical and Mental Rehabilitation are required to observe the Code of Ethics set out in the following fourteen rules. The regulations governing the interpretation and application of the Code are provided for in the Constitution of the Association for Physical and Mental Rehabilitation, which also provides action to be taken in the event an Active Member fails to observe any part of the Code.

An Active Member of the Association is hereafter referred to as "a Member."

1. A Member shall comply with the Rules of the Constitution of the Association for Physical and Mental Rehabilitation for the time being in force.
2. A Member shall not at any time, either in his professional capacity or otherwise, undertake to give, or accept responsibility for, any treatment unless under the supervision of a physician who is legally licensed to practice in his state or commonwealth.
3. A Member shall not at any time, either in his professional capacity or otherwise, undertake to give, or accept responsibility for, a form of treatment in which he does not hold a recognized qualification.
4. A Member shall not at any time, either in his professional capacity or otherwise, discuss with a patient, or within a patient's hearing, any treatment or other professional matter in such a way as may be calculated to bring doubt or discredit on the professional skill, knowledge, services or qualifications of any other registered medical auxiliary or professional colleague or any other person in the medical field.
5. A Member shall not, for the purposes of obtaining patients or work, or of promoting his own professional prestige, directly advertise himself in any manner not consistent with the ruling of the American Medical Association and the Association for Physical and Mental Rehabilitation.
6. A Member shall at all times, in his professional capacity or otherwise, respect the status of, and show courtesy to, his medical seniors, his own departmental superiors or staff, and to his professional colleagues.
7. A Member shall at all times, in his professional capacity or otherwise, give the best of his skill and knowledge when treating any patient, without prejudice and irrespective of financial remuneration.
8. A Member shall report to the physician accurately, and with adequate frequency, the patient's progress and response to treatment. He shall report to the physician immediately, if or when, the patient exhibits responses which are not normally expected and shall report any accident which may occur in the course of treatment.
9. A Member shall, in his professional capacity, maintain a clean and tidy appearance, shall maintain identification with his profession, and shall wear a uniform which is acceptable to the institution in which he works.
10. A Member shall faithfully observe the conditions of his appointment with an employer, whether these conditions have been agreed upon verbally or in writing.
11. A Member shall hold any information coming to his attention regarding a patient as confidential and consider it "privileged communications." Such information will not be made available to anyone except those responsible for the patient's medical care.
12. A Member shall not at any time, either in his professional capacity or otherwise, act in such a manner as to bring discredit upon his colleagues or the Association for Physical and Mental Rehabilitation. He shall maintain integrity and discipline in personal behavior so as to sustain and enhance public confidence in his profession.
13. A Member shall publish only information and opinions which can be reasonably expected to be a scientific contribution to the field of rehabilitation.
14. A Member shall strive at all times to improve his professional knowledge, skill and efficiency and thereby increase the value of his contribution to the field of rehabilitation.

Submitted by the Ethics Committee, APMR, April, 1953, by Kenneth Dening, Committee Chairman.
Advisor: Fritz Friedland, M.D.
Committee Members: Daniel Bennett, Rudy Jahn, Samuel C. Burchart, Arlie Hughes.

News and Comments

EXCERPTS FROM TB 10 A-357

On March 8, 1954, the Department of Medicine and Surgery, Veterans Administration, Washington, D. C., issued a Technical Bulletin dealing with all phases of CORRECTIVE THERAPY.

"The purpose of this bulletin is to outline specific policies for the Corrective Therapy Section in hospitals, centers and domiciliaries." It defines Corrective Therapy as: "A medically recognized and approved treatment service contributing to the overall rehabilitation effort of the physically sick and handicapped through application, for therapeutic purposes, of medically prescribed activity of an exercise and self care nature."

It states that Corrective Therapy is: "concerned with the prevention of deformity and the treatment of physical and mental disability resulting from disease or injury." It points out that: "Corrective Therapy stresses working *with* as well as *on* the patient through provision for cooperative relationships in which the therapist teaches and directs while the patient himself accomplishes the desired objectives."

It further states: "Corrective Therapy is the application of the principles, tools, techniques and psychology of remedial physical education, to assist the physician in the accomplishment of a prescribed objective. This implies not only education *of* the physical, but education *through* the physical."

This twelve (12) page bulletin includes a discussion of the scope, general policies, procedures and techniques, staff, in service training, uniforms, supplies and equipment, and records.

In presenting the Scope of Corrective Therapy, it states that: "Corrective Therapy utilizes all three phases of medicine, viz. (1) Prevention, (2) Diagnosis, prognosis and treatment, and (3) Rehabilitation.

Under the heading General Policies, the bulletin outlines the type of clinical data to be included in the request for treatment by the prescribing physician.

The Bulletin suggests:

1. Clinical diagnosis and specific condition or disability to be treated.
2. Pertinent medical history and findings.
3. Special considerations (precautions).
4. Treatment objective and desired results.
5. Specific therapeutic procedures or techniques desired.
6. Date for patient re-examination by the physician.

"For patients with certain types of conditions requiring extended hospital care, the activities prescribed may have as their objective maintaining the ability to perform certain activities of daily living and maintaining a level of organic functioning commensurate with the patient's condition, with a minimum of nursing care."

The Bulletin authorizes, under "Procedures and Techniques":

1. Adapted therapeutic physical activities
   - (a) Specific and general remedial exercises (passive and active) including the three categories of voluntary movements:
     - 1 Assistive movements which involve suspension, supportive and active assisting techniques, including active self-assistive exercises.
     - 2 Resistive movements, with resistance being given manually or by mechanical devices . . .
     - 3 Free movements, involving active exercise in all of its ramifications. . . . These movements include concentric, eccentric and static exercises, as well as the complete range of the natural activities of physical education.
   - (b) Ambulation and elevation techniques, involving gait training with or without the use of braces, canes, crutches.
   - (c) Neuromuscular coordination activities involving orientation in space, eye-foot, eye-hand, arm-leg patterns, including reciprocal motion in balancing and walking; postural correction in walking, standing, sitting and lying; substitution activities; progressive relaxations techniques.
   - (d) Formal and Free exercise, involving use of rhythm.
   - (e) Therapeutic hydrogymnastics.
   - (f) Respiratory efficiency exercises.
   - (g) Care and functional use of leg prostheses.
   - (h) Self Care activities.
   - (i) Motivational exercise experiences of a purposeful, meaningful and interesting nature, specifically oriented toward the accomplishment of psychiatric objectives.
   - (j) Instruction in the use of manually controlled motor vehicles for the severely disabled.
   - (k) Special activities for the blind, involving foot travel, health maintenance, reconditioning, motivation and adapted skills.
   - (l) Physical conditioning and physical adaptation for work demands involving development of organic efficiency.
2. Tests and Measurements and Other Evaluating Devices. . . . for the determination of strength, endurance, coordination. self-care ability, and range of movement and observational data, to evaluate patient's level of and capacity for purposive behavior readjustments.

The techniques to be used in treating General Medical and Surgical Psychiatric and Neurological patients are outlined under this section on Procedures and Techniques.

The "Examples of Prescriptions" are given for the patient with hemiplegia; an A/K amputation; a schizophrenic, catatonic type; a menisectomy; post-operative and a traumatic spinal cord injury.

Staff organization and responsibilities are outlined. In Service Training, Uniforms, Supplies and Equipment and Records are all discussed and outlined, making the bulletin very complete.

This Bulletin will be most helpful to all concerned. Every active member of the Association should be thoroughly familiar with its contents. It could well serve as the subject matter for panel discussions at Chapter meetings. The entire membership should be very grateful to Dr. John Elsele Davis for this publication.

EXCHANGE SUBSCRIPTIONS

A recent addition to the Journals received by the Editor, is the ORTHOPEDIC AND PROSTHETIC APPLIANCE JOURNAL, published jointly by the Orthopedic Appliance & Limb Manufacturers' Association and the American Board for Certification with Headquarters at 336 Washington Building, Washington 5, D. C.

It publishes articles of interest to therapists who work with paraplegics, and amputees. The March issue shows an interesting development of what has been frequently called a "gadget board" used in the training of the upper extremity amputee. There is a Portable Walk-aid Railing illustrated in the advertisement of the Leimkuehler Limb Co., Blackstone Building, Cleveland, Ohio, that would solve many construction problems of the patient with paraplegia. This Journal contains many articles of interest to Corrective Therapists.

SHORTAGE OF THERAPISTS ACUTE

Release Number 44, dated August 5, 1953, of "The Occupational Outlook Review" from the Veterans Administration, is extremely interesting. In speaking of occupational therapists it says, "Occupational therapists registered with the American Occupational Therapy Association numbered 4,000 in 1952 but only 2700 were actively engaged in the profession. Only 400 of the 4,000 were known to have transferred to other fields of work. The remainder had temporarily or permanently retired from the profession." This loss of personnel seems characteristic of any profession employing women predominantly." The number of registered occupational therapists increased from 600 in 1941 to 4,000 in 1952. The number of training centers also increased five-fold. The increase in the supply of qualified personnel has not kept pace with the increase in demand. If present enrollment, graduation and attrition rates continue, it will not be possible to train the number of personnel needed in occupational therapy in the foreseeable future."

This same review states, "qualified physical therapists numbered about 4,500 in the beginning of 1952, far below the number needed. Many institutions and agencies were unable to expand facilities or establish new departments because of lack of

personnel." Here again is evidence of a critical shortage of qualified therapists.

A similar condition exists in the field of corrective therapy where the number of trained personnel is not adequate for the number of jobs available. With the shift in emphasis from the passing of legislation to increase welfare, to the investment that comes from adequate rehabilitation of the disabled, it is quite evident that this need for therapists will continue to be critical.

WORLD VETERANS FEDERATION: NEWS SERVICE

WVF Has Permanent Representative At The United Nations

UNITED NATIONS (WVF)—Jacques Katel was recently appointed the World Veterans Federation's permanent representative to the United Nations. The WVF has class B consultative status at the UN and takes part in the work of the Economic and Social Council of the UN and its various commissions. Mr. Katel will work with ECOSOC and will also recommend to the WVF ways and means of supporting the UN.

Mr. Katel is a veteran of the French army. He has a degree in law from the University of Paris and for six years was a correspondent of the French Press Agency (AFP) at the United Nations.

Increase In The Number Of Blind In The United States

NEW YORK (WVF)—The number of blind persons in the United States has increased from 255,000 in 1948 to 308,000 in 1953. This conclusion was reached by Dr. Ralph Hurlin, deputy secretary-treasurer of the Russell Sage Foundation and chairman of the statistics committee for the blind.

Dr. Hurlin said that "In addition to cataract and glaucoma, the most common causes of blindness are the illnesses of old age. Infectious diseases which caused great damage in the past have been eliminated in large part by medical progress."

SOCIETY REPORT FINDS SERVICES FOR DISABLED A WORLD NEED

Industrial development, successful campaigns against mass disease, and longer life as a result of improved medical services have all increased the number of disabled persons throughout the world and given new emphasis to the need for adequate rehabilitation services, it was stated today by Donald V. Wilson, Secretary General of the International Society for the Welfare of Cripples, in connection with the publication of the Society's annual report for 1953.

"While our increasing ability to preserve life is gratifying," Wilson said, "We must recognize that many whose lives are saved are left with physical conditions which seriously handicap them unless specialized medical, social, vocational and educational services are available."

"Unless it is accepted that the arms and legs of workers are commodities which must be expended in the interests of industrial production, it cannot be suggested that industrial development is socially sound without a parallel organization of health and welfare services to meet problems such as those faced by the injured workman."

Progress in establishing services for disabled persons in many parts of the world is being achieved through the cooperative efforts of the United Nations, the UN Children's Fund, the World Health Organization, the International Labour Organization, voluntary agencies such as the International Society for the Welfare of Cripples, and many public and private groups in the various countries.

In outlining the program of the International Society, the publication indicates that the principal needs of those developing rehabilitation programs in the less developed parts of the world are for trained personnel, current information and counsel on the sound development of services. Through its International Rehabilitation Information Service, the Irving Geist International Film Library and other specialized facilities to assist in the international exchange of personnel and in the provision of expert guidance, the Society undertakes to meet these priority needs. During 1953, the report states, service of this kind was provided by the International Society to persons and organizations in more than fifty countries.

The International Society for the Welfare of Cripples is a federation of national organizations serving the physically handicapped in twenty-six countries. Its United States affiliate is the National Society for Crippled Children and Adults. Recognized as the principal international non-governmental organization devoted solely to the welfare of all handicapped persons, the Society has been granted consultative status by the United Nations Economic and Social Council, the Executive Board of the United Nations Children's Fund and the World Health Organization.

EMPLOYMENT SERVICES FOR DISABLED VETERANS

The rehabilitation department of the World Veterans Federation has released from the Paris office a report of the employment systems now in operation in member countries. This interesting report calls attention to the use of the voluntary and compulsory systems now operating. As typical of the two systems, those of Great Britain representing compulsory type and the United States representing the voluntary system, are explained in some detail. The compulsory employment with a quota is accepted by most European countries, but Israel is the only non-European country where it is in force. The report also includes a brief account of the employment services for the disabled in Czechoslovakia, the German Democratic Republic, Hungary and the U.S.S.R. The present report is based on replies to a questionnaire, the results of which were issued in October, 1953. The original report contains 87 typed pages and an appendix showing the annual pension rates for disabled veterans in the member countries.

The report and the three supplements that have been issued since the release of the original report contain much additional information. The report shows the medical care, pensions and allowances and what is being done in vocational rehabilitation. This report gives convincing evidence of the worldwide interest being taken in behalf of the veteran. An appreciation of the enormity of the problem should impress anyone who will take time to study these reports. These reports may be secured from the New York World Veterans Fund, Carnegie Building, 345 East 46th Street, New York City, New York.

REHABILITATION'S ROLE IN REDUCING COMPENSATION COSTS SUBJECT OF CONFERENCE FOR INSURERS, PHYSICIANS AT INSTITUTE FOR THE CRIPPLED AND DISABLED

"Rehabilitation: Its Effects in Reducing Compensation Costs" is the subject of the third annual conference for compensation insurers and physicians sponsored by the Institute for the Crippled and Disabled, rehabilitation center in New York City, it was announced today by Willic C. Gorthy, Institute Director and Conference Chairman.

The conference took place on Wednesday, April 7, 1954, 9 A.M. to 4 P.M., at the Institute, 23rd Street at First Avenue. It was opened by the Hon. Mary Donlon, Chairman, New York State Workmen's Compensation Board, and Mr. Bruce Barton, Chairman of the Board, Batten, Barton, Durstine and Osborn, Inc., and Institute President.

The luncheon speaker will be the Hon. Archie O. Dawson, Commissioner Moreland Commission for the Study of Workmen's Compensation Costs, State of New York.

At this year's event, Mr. Gorthy said, all points of view, including those of the compensation carrier, government agency, rehabilitation agency and the claimant, will be presented by authoriites who will concentrate on the application of rehabilitation to the cost factors of compensation insurance which are becoming increasingly important.

The morning session will include a presentation of the rehabilitation philosophies and operating procedures of compensation carrier, large and small. Speakers were Mr. Ctanwood L. Hanson, Vice President, Liberty Mutual Insurance Company, and Mr. J. Clark Breen, Supervisor, Compensation Rehabilitation Division, American Fore Insurance Group.

The "P.R.S."—Preliminary Rehabilitation Survey—a new and long needed service for carriers which do not have large rehabilitation departments, will be announced and demonstrated

by the Institute staff under the direction of Miss Arpie Shelton, Coordinator of Compensation Insurance Cases.

The luncheon accommodating 300 compensation insurance executives, claims people and physicians, was followed by a series of clinical demonstrations showing injured workmen being rehabilitated at the Institute. This was part oof a tour of the rehabilitation center's completely modernized and expanded facilities.

A panel of distinguished physicians representing the carrier, government and the rehabilitation center will then present their views on adequately timing and planning the use of rehabilitation medicine to achieve more effective results.

The panel will be moderated by Dr. Robert C. Darling, Chairman of the Institute's medical board and Professor of Physical Medicine and Rehabilitation, College of Physicians and Surgeons, Columbia University. Panel members included Mr. Willis N. Weeden, Medical Director of the New York State Workmen's Compensation Board, Dr. Robert 'OConnor, Medical Director, Loss Prevention Department, Liberty Mutual Insurance Company, Dr. John P. Stump, orthopedic surgeon, and Dr. Edward E. Gordon, Institute Medical Director.

PLAN CLASS FOR REHABILITATION WORKERS

Ohio State University will offer a summer workshop on the education of Crippled Children from June 21 through July 9. Primarily designed for teachers of crippled children, the course will be open to graduate and undergraduate students.

The workshop will deal with problems relating to physical, mental, social and emotional growth of handicapped children, with special attention to integrated services. Those desiring to attend should communicate with Herschel Nisonger, 321 Arps Hall, Ohio State University, Columbus 10, Ohio.

Ohio State University is developing courses for Rehabilitation workers.

OF INTEREST TO VOCATIONAL COUNSELORS

The Bureau of Labor Statistics, U.S. Department of Labor, (in Release No. 48 dated December 4, 1953) gives an encouraging picture of employment and wages. This pamphlet "Occupational Outlook Review" shows: 1. Non-farm employment to be continuing at high level; 2. Factory earnings in October 1953 remain high despite less overtime work; 3. Job outlook to be good in industrial chemical industry; 4. Educational attainments of veterans to exceed that on non-veterans; 5. That earnings of workers in building trades, local transit operation, work clothing, manufacturing and hosiery manufacturing were increasing.

Contained in this pamphlet is a cumulative subject index.

This timely and authentic information well condensed into 20 pages should be of help to any one interested in total rehabilitation of the patient. It should be particularly helpful to vocational counselers; manual arts therapists and educational therapists. It is available without charge. It shows what has taken place since the publication of the 1951 Occupational Outlook Handbook.

MANUAL ON CABLE-TENSION STRENGTH TESTS

A new manual on "Cable-Tension Strength Tests" the first of its kind ever compiled, has been published by Dr. H. Harrison Clarke, director of graduate study at Springfield College.

The manual consists of 38 original strength tests which have been formally tried on patients with orthopedic disabilities in three hospital situations. At the U. S. Naval Hospital in Chelsea, the Bronx Veterans' Administration Hospital, and the Mayo Clinic the tests were considered by orthopedic physicians and doctors of physical medicine, to be satisfactory when used on convalescent cases.

Procedures, testing equipment and drawings of method are included in Dr. Clarke's manual which was printed locally at Brown and Murphy Co., in Chicopee. Six different articles describing the research on these tests have been published by Dr. Clarke. Many of the tests were originated by Dr. Clarke while serving in the Physical Reconditioning Branch of the Army Air Forces Personnel Distribution Command during World War II. The cable tension tests were proposed for objectively measuring the strength of affected muscle groups involved in orthopedic disabilities.

The U. S. Office of Naval Research subsidized the research in studying the 38 tests involving movements of the finger, thumb, wrist, forearm, elbow, shoulder, neck. trunk, hip, knee, and ankle joints. The research was conducted in the Physical Education Research Laboratory at Springfield College with the aid of many graduate students. An early trial of the tests was conducted at the Naval Hospital at Chelsea. Tests were administered to 19 convalescent patients recovering from such conditions as arthritis, bone-pegging operations, arthrotemies, bursitis, and ruptured itervertebral disk. Patient status ranged from those in the early stages of convalescence to those who were nearly ready for return to duty. Reports of later studies of the use of the tests, at the Bronx VA Hospital and the Mayo Clinic have not been published elsewhere but have been acclaimed "satisfactory and encouraging."

"THE HIGHER HORIZON"

Mr. Willis C. Gorthy, Director of the Institute for the Crippled and Disabled in New York City, recently gave an address to a group of National Magazine Editors in which he stressed the vocational rehabilitation of the handicapped and the feasibility of hiring the people who had been trained following the onset of their disabilities.

Mr. Gorthy stated that rehabilitation was a team process in which no particular therapist or worker was independent of the other. The rehabilitation center can sometimes perform "the so-called miracle" in bringing people back to an independent status, but the missing link, the placement of the handicapped person in a job for which he has been suitably trained, must be taken more and more into consideration.

Business and industry take great care to place people in jobs for which they are best fitted. How many people who have normal health are as adequately trained or well suited for the job as the person who has been trained at the rehabilitation center and deemed by vocational advisers as well adapted to their pursuits.

The challenge is now up to industry and business. Experience has proven that handicapped people who have been trained for a suitable job are good risks and make good employees. Imagine the chagrin and disillusionment of the handicapped person who has fought his way back against heavy odds, been trained in a job which he is able to do, and been denied the chance to earn an independent living.

PHILLIP J. RASCH ACCEPTS NEW POSITION

Mr. Phillip J. Rasch, whose Book Review Column is widely read and appreciated by the membership and editorial staff, has recently been appointed as Associate Professor of Research assisting Dr. Lawrence E. Moorehouse, Head of the Los Angeles County Board of Supervisors Research Unit. Dr. Moorehouse is on a year's leave of absence from the University. Mr. Rasch is enthusiastic over his opportunities. He will continue as Book Review and Abstract Editor for the Journal. Mr. Rasch has been among the "old faithfuls" of the Association with his very continuous preparation of reviews and abstracts. The Association is happy to hear of this new opportunity for "Phil."

WORKING PROVES GOOD MEDICINE FOR SICK HEARTS

Going back to work is not only an economic necessity for most heart disease patients, it's likely to be good for their health. This is borne out by the history of 350 patients aided by the Work Classification Clinic of the Cleveland Area Heart Society in its first three years of operation.

After two years of close follow-up by the Clinic, its patients' health history afforded striking refutation of the false idea that heart disease inevitably gets worse. Rather, in almost one-fourth of its patients, definite cardiac improvement was recorded while a large majority experienced no change. The percentage of those whose condition worsened was comparatively small: 11.7 percent.

Substantial numbers, the Clinic found, were not only in better health but earning more than they had before getting sick. What's more, many who had been unemployed when they first came to the Clinic were later able to find jobs. Nearly 58 percent had been out of work on their first visit: 41.6 percent for reasons related to their illness. On a subsequent visit, 60 percent of the previously unemployed had jobs. In the first two years, it was estimated they would earn a total of more than $425,000! Yet, it had cost only two percent of this sum to provide them with the Clinic's services.

The Work Classification Clinic gave a large share of the credit for this record of successful rehabilitation to the emotional security made possible by the careful evaluation of each patient's safe work capacity. A Clinic report called "supportive reassurance" the most urgent of all needs.

These were typical heart patients, with the various forms of heart diseases occurring among them in the frequencies statistically characteristic of the national cardiac population. Their work background was substantial. Their prior earning capacity was impressive. It was important to the community, as well as to the patients themselves that rehabilitation not only restored earning capacity but that, in almost half the cases, improvement in economic status followed. Furthermore, almost three-fourth were able to return to their former occupation or industrial classification. Only 26 percent had to find a new occupation.

"Properly placed persons with heart disease are not handicapped workers," the Clinic report concluded. "The patients with heart diseases worked well. Less than two days per hundred were lost because of illness. There was no increased risk to the employer. There have been no industrial compensation claims . . . The key to the successful placement of a person with heart disease is selective placement in which the energy requirement of a job is less than that which a person with heart disease can perform."

(Courtesy "The American Heart"—Fall, 1953) Pub. by American Heart Assn. and its Affiliates.

(Continued from Page 88)

PROGRESS REPORT OF THE EDUCATION COMMITTEE

During the past seven years the growth of exercise therapy, in the rapidly developing field of rehabilitation or restorative medicine, has progressed to the point where the demand for adequately trained therapists far exceeds the supply. It became evident to this committee four years ago, that the didactic and clinical training facilities offered at the various colleges and universities must be thoroughly examined to see how well these educational needs were being met.

The study of course offerings and clinical training opportunities and facilities presented such a wide variety of course combinations and clinical opportunities, that this committee began evaluating the present training status, in this phase of physical education, to determine the desirable course combinations that could be used as a guide, for the professional training of this group of physical educators, who are so vitally needed in hospitals, schools and rehabilitation centers.

The findings of this evaluation resulted in a three year study that has just been completed. A suggested guide for this specialized education has been developed. The Medical Advisory Board has evaluated and approved this guide, and a combined report is being made available to the various colleges and universities interested in the progressive development of this specialization in the field of physical education. Space limitation does not permit the publication of the full report at this time.

Submitted by Karl K. Klein,
Chairman, Educational Committee

States and Communities Must Act If Disabled Are To Benefit Under Eisenhower Rehabilitation Program

Increased Federal Funds To Be Available Only If Matched By States

WEST POINT, N. Y.—Five hundred rehabilitation specialists from New York, New Yersey, Pennsylvania and Delaware were informed today that if President Eisenhower's program for rehabilitation of the disabled is passed by Congress, the handicapped in their states will receive little, if any, additional benefit unless communities take the initiative in determining local needs for expanded rehabilitation services.

E. B. Whitten, Executive Director of the National Rehabilitation Association, told the third annual conference of the organization's Region II, at its opening session at West Point, N. Y., that federal funds will be available only to support state and local efforts, and will not be made available independent of these efforts.

"There are two million disabled in this nation who are not receiving any kind of rehabilitation right now," Mr. Whitten said, **"This number is increasing by 250,000 a year.** The present joint Federal-State rehabilitation program provides service annually to 60,000. This means that the number of unrehabilitated disabled is soaring each year and an economy-minded President has recognized the soundness of rehabilitating the nation's disabled. He is calling for an increase in the annual Federal rehabilitation investment from its present figure of 23,000,000 to 60,000,000 by 1959."

States will not receive greater appropriations for rehabilitation of their disabled unless they are willing to pay their share of the total cost of the program. To do this, existing state legislation will have to be amended in many cases. Pending Federal legislation provides funds to assist States in establishing necessary rehabilitation facilities, diagnostic and treatment centers, chronic illness hospitals and nursing homes.

Another phase of the program is the increase of appropriations for actual rehabilitation services and a broadening of the categories of persons eligible for care. Other pending legislation calls for waiving payment of social security premiums by person determined to be disabled by State divisions of Vocational Rehabilitation.

Mr. Whitten presided at a panel discussion of President Eisenhower's proposed rehabilitation program. The panel also included Dr. Herman E. Hilleboe, Commissioner of the New York State Health Department; Dr. James E. Allen, Deputy Commissioner of the New York State Department of Education; Russell J. M. Dean, special assistant to the director, Office of Vocational Rehabilitation, Federal Department of Health, Education and Welfare and Dr. Morton Seidenfeld of the National Foundation of Infantile Paralisis.

Dr. Hilleboe reported that the State hospital survey and Planning Commission is exploring ways in which additional hospital funds would be used if Federal funds are appropriated.

"Through regional hospital counsel and the State hospital and planning commission, we would survey the needs of New York State's disabled. Recommendations would be submitted to the State Medical and Hospital Association so as to obtain their professional views. Since this effort would eventually become a request for grants-in-aid from the Federal government, the commission would coordinate with the State Committee on Fiscal Affairs."

Dr. Allen pointed up the meaning of President Eisenhower's rehabilitation program by saying it represents "a new achievement in cooperation and collaboration among many levels of government, as well as private rehabilitation agencies."

The rehabilitation legislation which Congress is now considering is designed to build a broader foundation on which the program may continue to grow, according to Russell Dean of the Office of Vocational Rehabilitation. Mr. Dean cited the establishment of the institute for the Crippled and Disabled in New York City, the National Tuberculosis Association and the Rehabilitation of World War I Veterans as milestones in the beginning of modern rehabilitation.

"Decisions made this year in rehabilitation will direct the future of this activity for several years to come," Mr. Dean said. "The human need is urgent. With rehabilitation better understood today than ever before, and with the President's program calling for the unification of public and private rehabilitation efforts into a closely united front, the public and its rehabilitation specialists are in a position to make a greater contribution to the welfare of our disabled than ever before."

"Our nation can ill afford to lose the productive power and talents of those who are idle today because they are disabled. We need them as active, productive citizens. We must keep building our resources for rehabilitation, b o t h in the State-Federal Program and among our many fine voluntary organizations. We need more stress on careful selective placement of the handicapped through the Public Employment Service, in industry and in the Federal Establishment."

DWIGHT D. EISENHOWER,
President of the United States

Association for Physical and Mental Rehabilitation

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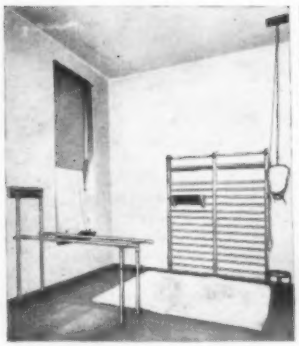

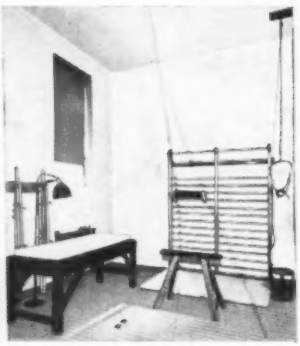

Views above and left show well-equipped rooms in the physical therapy department of Michael Reese Hospital, Chicago. Porter supplies stall bars, gym mats, chest weights and a wide variety of highly specialized corrective devices described in a catalog which is yours for the asking.

Porter Corrective Therapy Apparatus is carefully manufactured from designs based on the recommendations and experiences of authorities in the field. Many of the devices are standard equipment in Physical Medicine Rehabilitation and Corrective Gymnastic work.

A catalog containing these standard items will be mailed on request. For therapists requiring special devices, Porter's engineering department is available for working out new designs to meet new requirements.

Backed by nearly a century of quality manufacturing, The J. E. Porter Corporation is the world's largest makers of gymnasium, playground and swimming pool equipment. The same reputation that has made Porter a famous name among schools, universities and recreation leaders is your assurance in the choice of Porter as a source for dependable Corrective Therapy Apparatus.

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